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ORIGINAL ARTICLES.

MATERNITY HOSPITALS AND THEIR RESULTS.*

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Every obstetrician's dependence in emergencies must be upon himself. If the resources of his information and skill are so limited that he must call in extraneous aid, the lying-in woman is exposed to other risks than those of delay—those of dangerous drugging or ignorant surgical interference. The resourceful surgeon is one with many experiences, and the same fact applies to the successful obstetrician. The lessons of three or four hundred maternity cases never yet made an eminently skillful obstetrician — one to be depended upon in all of the many emergencies liable to be met with in lying-in cases.

The problems, those tests of the practical wisdom of hard earned and well learned lessons, of the very genius of obstetrical skill, arising in many emergencies give no time for settlement by consulting the books, by reference to reported cases or by calling in outside aid. In fact the lessons of the books in many cases would be misguiding. Through many and painful experiences, the lessons of sad results, we have unlearned many of the teachings of the old books.

There is grand promise in the fact that the profession of the period has in it the impulse and the spirit to grow away from and above the old benches. One of the most gratifying and hopeful results of the thorough training which comes of wide obstetrical experience is the doing away with the too free use of instruments in delivery.

Certainly with the lessons of more than two centuries of forceps experience we should be able to form an enlightened opinion as to the value or risks of their use. The consensus of the best authorities, of the opinions of men who speak from the most extended observation and experience, leads to the conclusion that the mortality attending non-interference is less than that attending the use of forceps. In this relation our debt is great to the Dublin school of obstetricians. Dr. Clark, for long master of the Rotunda, stands out as the one heroic figure in the van, of those pioneers.

The exigencies requiring the use of instruments are not of such frequent occurrence as formerly believed. Now the citing of a case of instrumental interference is usually accompanied by an elaborate statement and explanation of desperate and otherwise unavoidable conditions. We have learned the evil and bad results of hurry; the welfare of mother and child are no longer to be sacrificed to the exigencies of private practice. With the growth of general intelligence our patients become less tolerant of undue haste, they have an enlightened appreciation of the issues involved, and of well-timed and skillful work, and they make few mistakes in their book keeping, in charging to the correct cause unhappy or fatal results. It is not a wild prophesy when we say that the time is not distant

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when in all dense communities obstetrics will be a specialty, and in the ranks of its practitioners there will be the cleanest, most cultured and scientific men of the profession. The issues, the often fearful sequelæ of ignorant or ill-advised treatment in cases of midwifery, furnish a strong warning, a resistless argument against the employment in such practice of the inexperienced and unskilled.

The advantage of patients in maternities over private lying-in patients lies in the fact that they are under the strict surveillance of experienced medical men, aided by nurses trained in all the principles and methods of their art. All the environs and appointments are under the control of well defined and intelligent authority,—sanitary and hygienic conditions are of more easy control, the evils of dense crowding can be avoided, and an ideal cleanliness more nearly attained. There are less injuries in maternities from attempts to expedite labor. And from this cause there are more evil consequences than from delay or any other cause; nature is interfered with in doing her part of the work. There is no branch of medical science in which we have so many understood certainties as in obstetrics.

Where our knowledge is defective or incomplete, it is not due to lack of authentic source, of easy and approved means—but to the lack of energy of use. There exist open opportunities of bed-side experience and training, many open doors for clinical study and research, yet there are very many—and the best—kept closed. For this the profession is responsible. It is their mission and duty to heal—it is also their mission, duty and royal right to the use of every avenue through which the best lessons are taught. The tyros going out from our college benches into fields of private practice are ill-equipped for successful obstetrical work, they carry many risks to mothers. We are not claiming that the science or its practice in the hands of any one is perfect,—that cannot be claimed of anything in which our humanity is involved.

There has been gathered a very rich harvest of the results of cleanliness in maternities and private obstetrical work, and we have in these results promise of yet better results in the future. As we grow to know how very simple is our art, how near to nature is its successful practice, we feel less disposed to take off our hats when we speak of our individual work and its success.

It has not been long since obstetrics was the one department and dominated the field of gynecology. Progress has been such that gynecology no longer suffers the reproach of being a pseudo-science, working by guess, by vague suspicion, gaining advances by mere experiments upon human life, groping in the dark in attempts at settlement of problems of health and life, but has grown to work hand in hand with obstetrics and is gaining increased recognition whereever suffering exists. The lessons of both have come to live with us. In both experience teaches the value of cleanliness—that we have no right to tolerate filth in any of its forms—nor to blunder in our work.

The signal advances in obstetrics as in gynecology are of our own generation. As to many anomalies, obscure troubles, the general practitioner has become enlightened, he has acquired the important knowledge which enables him to determine where purely medical or palliative treatment fails, and the only resource left is surgical interference. The obstetrician is not practicing what his forefathers wore out and threw away. Old theories and beliefs have been gradually giving way before the assault of our better facts. Each day finds fewer superstitions in practical medicine and surgery. Dr. Angus Macdonald in a Report of the Royal Maternity and Simpson Memorial Hospital, Edinburgh, condenses truths worthy of mention here: "The more I see of midwifery and gynecology, the more I am confirmed that the safety of patients urgently requires the diligent use of cleanliness. I feel more and more satisfied that operations on the genitals, of whatever sort, are specially dangerous, not so much because of the inflammatory reaction, which is likely to be severe in itself as because there is extreme facility for septic absorption. This is particularly the case where, from aggregation of septic influences, there is specially apt to arise putrescent materials of highly toxic qualities."

The reduction of the mortality in lying-in hospitals from 20 per cent. to almost nil cannot be credited so much to the use of antiseptics as to a more enlightened and strict sanitary regime, a more strict

cleanliness. The constant improvement in our operative statistics testifies the value of surgical cleanliness, scrupulous aseptic precautions. The great increase in the average of city life is largely due to greatly increased observance of health conditions. The measure of the physician's responsibility in these lines cannot be over-estimated.

He can kindly, where that will serve, or sternly, where that is needed, urge the lesson that to live amid bad hygienic conditions, in an atmosphere of domestic malaria means disease and death,—that pure, healthy in-door air, freedom from poisonous effluvia and musty odors, cannot be had without the most scrupulous cleanliness, the removal of all bodily excretions, of everything offensive; animal, fluid and organic. There are out-door impurities, sources of air pollution, we cannot at all times and under all circumstances wholly guard against. Streets, alleys and courts are often sources of atmospheric infection over which we have little or no control. The most we can do is to educate public sentiment in the line of a wise sanitary policy and back its administration.

The members of the medical profession have it in their power to make themselves the sovereigns in the enforcement of the wise dicta of sanitary science. They are the real educators in everything that pertains to the public health. The people are willing and anxious to learn the lessons through the practice of which they can avoid disease. The more the obstetrician and medical men generally, press home upon the public the vital truth of the preventibility of many diseases, the sooner we will have a popular understanding of the simple principles of sanitary science and a rigid practice of cleanliness. Let the physician teach the risks of filth infection to his clientele—send the lesson into private homes that bedding, carpets, floors, walls, every appurtenance and furnishing may be a source of uncleanness, that all forms of excretia and impure gases emanating from decaying organic substances are so much pollution.

The apology for this paper, if any be needed, lies in the importance of the subject, its importance to the profession, to communities, and its yet more grave importance to mothers. I would echo the voice of Holmes loud enough for warning. "The woman about to become a mother, or with her new-born infant upon her bosom, should be the object of trembling care and sympathy wherever she bears her tender burden, or stretches her aching limbs. The very outcast of the streets has pity upon her sister in degredation when the seal of promised maternity is impressed upon her. The remorseless vengeance of the law, brought down upon its victim by a machinery as sure as destiny, is arrested in its fall at a word which reveals her transient claim for mercy. The solemn prayer of the liturgy singles out her sorrows from the multiplied trials of life, to plead for her in the hour of peril. God forbid that any member of the profession to which she trusts her life, doubly precious at that eventful period, should hazard it negligently, unadvisedly, or selfishly!"

I presume a long and somewhat varied experience entitles me to speak plainly and the time for speaking plainly is always present, always *now*. As to the *conscience* with which I speak, that is mine. There are some things about which our national and inter-national medical congresses should speak in no uncertain tones; there are some things that we here at home and our honored brothers of Republics to the south of us should insist upon, everything associated with our profession, with our schools and all their agencies, with respective fields and departments of practice, is a sacred trust. A trust something more than narrowly individual, it is communism in all that it involves, its bond is to prolong and promote healthful human life. The trustees of our schools and maternities hold the highest trust existing in our communities, a trust that reaches helpless mothers and their more helpless off-spring, that reaches the unfortunate in every grade of life, and humanity is their care. Yet they only too frequently do not exercise wisdom and deliberation in the choice of teachers and masters. The time is fortunately not distant when they will be held to more strict account. We have long since proven that maternal deaths are avoidable, deaths not only from sepsis or child-bed fever, but from other causes as well, death in child-bed means an error of omission or commission. The mortality in maternity hospitals is now the lowest. Maternities have settled about all the important disputed points in obstetrical practice. The most perfect work has

been done in the maternities of Baltimore, Philadelphia, New York and Boston. Not only has this work been perfect from the standpoint of a low mortality, but the hospitals in which it has been done have done a great work in practical teaching, demonstrating beautifully two points: 1st, That a maternity can be run with a nil mortality; 2nd, That it can unite with its humane purpose practical teaching with a nil mortality. All this has been disputed both at home and abroad. The time is not distant in the future when the directors of maternity hospitals will not dare to appoint a man to direct or have official charge of such vital interests without a rich practical experience and sound judgment. They will be held responsible for the success of their trust, and it is to be hoped will be held criminally responsible for the choice of a person to such trust with no more pride of personal cleanliness and cleanliness of environment than a stable boy, dirty in all the term implies, morally and personally.

It is the teaching of this subject that is of so much vital importance to the profession. Very much of it is fed out from the old books and is worth very little more to the student than is an old almanac for dates. The student gets little of clinical or practical value and goes out from the college to study the science and art of his work upon helpless patients. Every day brings to our notice sad illustrations of the result of such miserably poor and inadequate obstetrical teaching. The directors or managers of our schools are responsible for imperfect, inadequate or false teaching; the profession and the community must and do so hold them responsible. They hold them responsible for the incompetent and unfit men they select to teach; for the injustice done worthy students and for the irreparable mischief worked in communities by obstetrical ignorance. Teachers should not be appointed on account of their pedigree, their family connections or their wealth, but for their brains, their knowledge of their subjects, their love and faculty for teaching, and for the honor and advancement of the school. About all some of those now holding responsible chairs in some of our oldest schools have to recommend them is a volume of prefixes to their names, suggestive of a medical and biographocal index. The shout goes up when doting relatives, maiden aunts and friends who secure their appointment "Now we have a professor of favored parentage, one dating beyond our accepted scriptural Genesis." At the claims of this class the Darwinian would indulge a philosophic smile and note fresh evidence in favor of his theory of the descent of the human species. There should be no small men, mentally nor morally, in the faculties of our great schools. The work of none of us is so well done but that it cannot be out-done—better done. Let each man go back and study the history of his own neighborhood in connection with obstetrical practice and he will scarcely escape being startled by the result.

Recently, within the past few weeks, several lovely women, those moving in the most cultured and refined of Philadelphia society have died in child-bed. Now these untimely and sad deaths are too frequent. In a majority of instances they are avoidable by the exercise of enlightened precautions, through the practice of that skill which comes of experience and without which no man should enter a lying-in-chamber. The old mock, tearful reverence, the pious humility with which the deaths in these cases are credited to providential dispensation will not longer answer. With each death the demand will grow stronger, more universal and angry for better and more thorough obstetrical teaching.

I speak for the pride and best hope of our land, the American student; for the best loved, the purest and noblest of our own or any other land, our American mothers.

THE YEAR of greatest growth in boys is the seventeenth; in girls the fourteenth. While girls reach full height in their fifteenth year, they acquire full weight at the age of twenty. Boys are stronger than girls from birth to the eleventh year; then girls become superior physically to the seventeenth year, when the tables are again turned and remain so. From November to April children grow very little and gain no weight; from April to July they gain in height, but lose in weight; From July to November they increase greatly in weight, but not in height.—*British Medical Monthly.*

TOTAL EXTIRPATION OF THE SCAPULA WITH THE ARM RETAINED.*

A. M. PHELPS, M. D.†

Mr. John N. B., of Mount Vernon, aged forty-two years, consulted me on November 21, 1891. I found a large

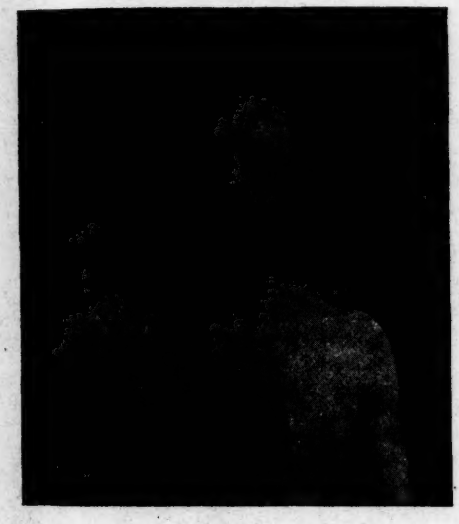

Fig. 1.

tumor, growing from the scapula, and involving its entire extent. Figures 1, and 2, convey a very correct idea of the extent of the deformity. He first observed the growth three years ago, as a hard, irregular mass, growing from the anterior border of the scapula. It has not been attended by pain until quite recently. He did not know what caused it.

I find that the tumor extends to the axilla, and up under the pectoral muscles, the scapula being somewhat movable. The tumor is nodulated, and the glands in the axilla are enlarged. His general health is good; his occupation is a book-keeper.

Dr. W. T. Bull and Dr. Robert T. Morris in consultation, advised extirpation of the scapula, and, if possible, saving the arm and clavicle. I proceeded to operate upon the case at the Post-Graduate Hospital, Doctors Plimpton Mooney, Kelly, and the house-staff assisting. The incision made was that of Langenbeck—see *A.* figure 2. This incision was from the upper and inner angle of the scapula, extending along its spine to the tip of the acromion process. Another incision was carried at right-angles with this line, to the inferior angle of the scapula. The arm was then severed from its attachment to the scapula. The superior flap was now turned upwards, the supra-scapular and posterior scapular arteries being secured; the inferior flap was quickly turned backwards, exposing the posterior border of the scapula, which was then tilted forwards and dissected from its base, the dissection including all of the muscles attached to the scapula, the infra-scapular artery being secured as the dissection proceeded. The scapula was cut away from its attachment to the clavicle, the muscles detached from the coracoid process and the whole removed *en masse.* A few bleeding points were now secured, and the deltoid muscle stitched carefully to the fibrous tissue

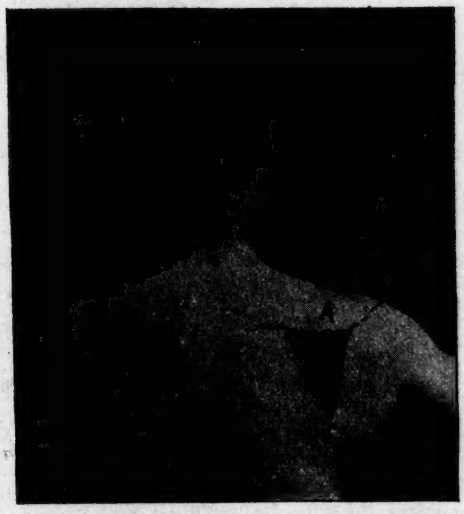

Fig. 2.

A. Langenbeck's incision showing slough.
B. As it should be from an anatomical standpoint.

about the end of the clavicle, the head of the bone resting well up underneath

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the acromion end of the clavicle. The wound was next carefully stitched up and dressed antiseptically, and the whole suspended in a sling to the side of the body.

The tumor was found attached to the second and third ribs quite extensively, and was with very great difficulty separated; the time of the operation, including the dressings was 57 minutes. There was no shock, and no higher temperature than 101° following the operation. At the first dressing, it was discovered that the inferior angular flap had sloughed (see *A*, fig. 2). This sloughing of the flap was caused by want of nutrition. The supra-scapular and posterior scapular arteries supply this portion of the flap and by Langenbeck's incision they were both cut. Then again, the angular portion of this flap, shelving up over the head of the

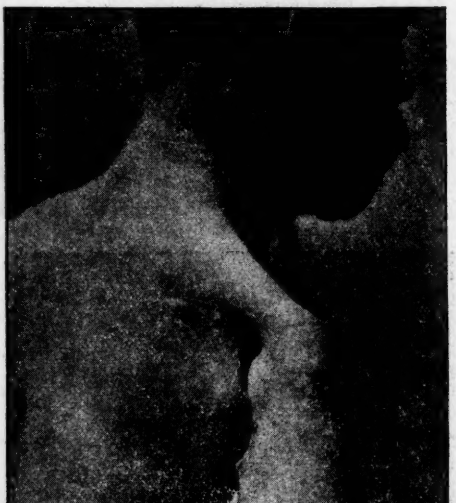

Fig. 3.

bone, did not come in contact with the subjacent tissue, therefore sloughing necessarily followed. This I found upon inquiry, was not an uncommon result where the Langenbeck incision was employed. To remedy this, I suggest that the incision and flap be made as in figure 2, *B*. This will secure a flap properly nourished by the supra-scapular and posterior scapular arteries, and probably would not slough; it certainly is an incision which should be tried, because the sloughing of the flap retards the healing process and endangers the life of the patient. The wound healed without pus, and the patient was discharged from the hospital at the end of three weeks.

Two weeks after his discharge, he was attacked with "la grippe," and one week or later, six weeks after the operation, he began coughing, and raised large quantities of pus. Dr. Wilcox diagnosticated a circumscribed empyema in the upper lobe of the lung. His report is here appended:

January 2nd, 1892. Contracted a severe catarrhal bronchitis. At that time dullness to middle of second rib on right side; line of dullness horizontal and running to vertebral spines.

Jan. 4th. Night sweats; cough out of proportion to severity of bronchitis; hectic; great prostration; absolute flatness in area noted above; distant respiration; vocal fremitus and resonance markedly diminished.

Jan. 7th. Empyema ruptured into secondary ascending bronchus of upper lobe of right lung. Six ounces of light colored, diffused pus evacuated.

Jan. 9th. Empyema ruptured into inferior outer angle of wound. One-half ounce of similar pus discharged. Direct connection between bronchus and wound, the cavity of which was cleared by coughing.

Jan. 12th. External orifice closed. Tympanitic percussion note over region named; high pitched amphoric respiration; few tenaceous rales.

Jan. 16th. Opening into bronchus closed; signs of slight dullness; somewhat distant respiration; few crepitant (pleural) rales.

Jan. 19th. Bronchitis entirely cured.

Feb. 1st. A traumatic exudative pleurisy had closed some of chest.

Feb. 2nd. Infection of this exudate from purulent bronchitis and not from wound.

Feb. 3rd. Resulting empyema.

Feb. 4th. Positive diagnosis from physical signs, when the contents of empyema measured less than seven ounces.

Feb. 5th. Adhesive pleuritis preventing general pneumothorax after rupture.

Feb. 6th. External opening allowing free emptying of pus cavity (important therapeutic indication).

Feb. 7th. Rapid healing of pus cavity by secondary exudative pleuritis.

This empyema opened into the bronchus and also externally at the upper border of the wound. From this time on recovery was rapid. The empyema was not produced by the trauma or by infection, but was due entirely to the attack of "la grippe," and was simply a coincidence. The wound was healed perfectly by April 4th, 1892. One observation which we made was that the exposed end of the humerus was entirely healed over at the end of forty-two days, the cartilage was gradually absorbed by granulations appearing through it, and the skin did not grow over the head of the bone until the cartilage was entirely removed by the granulating process. Although the power of motion at the shoulder is limited, the hand and arm are useful.

An examination made by Dr. Smith, the pathologist of the Post-Graduate Laboratory, showed that the tumor was made up entirely of fibrous material, and was not malignant. It is interesting to note that in this condition of non-malignancy, were found the nodulated appearance of sarcoma, the pain attending on sarcoma, and the enlargement of the glands which we would expect to find in malignant disease, or in sarcoma which was undergoing destructive changes. The patient up to date has remained perfectly well. There has been no return of the disease and to all appearance, he is a well man.

I have examined the literature upon the subject of total extirpation of the scapula, the arm and clavicle being retained and find up to the date of this operation, that there have been 118 cases reported, 58 of which were for tumors, 9 for caries and injury, 51 not reported upon. There were 25 deaths, 3 undetermined. The age varied from 8 to 70 years; the mortality was 22 per cent.

The conclusions at which I arrived are: (1) total extirpation of the scapula is not an extremely dangerous operation to perform, if care is taken to cut in such an order as to secure the supra-scapular, posterior scapular, and infra-scapular arteries; (2) in cases of malignant disease attended by extreme vascularity, I would suggest that the subclavian artery between the coracoid process and the thyroid axis be compressed by means of a large curved needle, transfixing all the tissues, carrying underneath everything a silk ligature which would be tied temporarily, thus controlling the hemorrhage. It will be remembered that the scapula receives its vascular supply superiorly from the thyroid axis, which is given off from the subclavian; (3) that Langenbeck's incision should not be used for the reasons already given. The curved incision which I suggest (fig. 2, *B.*) is based upon the vascular anatomy of the parts.

The Patent Medicine Business.

Light has been let into the patent-medicine business by a recent lawsuit in the English courts, wherein one Alabone, the proprietor of a specific, sued one Morton, his former manager, for stealing his ideas and testimonials and setting up an opposition trade. Alabone is an M.D. from Pennsylvania; Morton made no pretence of being a doctor. As has happened before in such cases, the ingredients of the Alabone consumption cure and its bogus nature came out in the trial, as did the qualities of some of the affidavits of cure. Alabone won his suit, but the judge in giving judgment in his favor suggested the propriety of having both the parties prosecuted for infringement of the Apothecaries' Act. The London *Times* suggests that the real victory in the case is with the public, which may profit by the disclosures made in the course of the trial as to the worthlessness of nostrums. But the mainstay of the patent-medicine gentlemen is people who do not concern themselves very much about the law reports. What they want is something to take, and they take that which is offered with the most persistence and recommended in the largest type. However worthless any particular patent medicine may be, it is nobody's business to make that worthlessness public, whereas it is the particular business of the proprietor that the medicine shall be systematically cracked up and put upon the market. The true way to kill off a patent medicine is not to demonstrate that it is of no value, but to invent a new one and advertise it in bigger letters. — *Harper's Weekly.*

COMMUNICATIONS.

LATERAL ANASTOMOSIS BY THE MURPHY BUTTON FOR ARTIFICIAL ANUS; RECOVERY.

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Mrs. H., white; age 50. The mother of four children, the youngest 13 years old. The husband of this patient called at the office on Friday, Jan. 6, 1893, for something for pain in the bowels. Furnished him appropriate remedies for an attack of intestinal colic. The patient not improving, I was called the next evening (Saturday) to see her and found her suffering extreme pain, located principally in the left umbilical region, with soreness on pressure at the point of greatest pain. The patient was slightly jaundiced and for constipation, the day before had taken a physic with one small stool resulting. The pain was accompanied by tenesmus and occasional vomiting of a bilious nature. Thinking I had an attack of biliary colic to treat, I resorted to proper medication alleviating pain with the hypodermic needle. Saw the patient again on Sunday. Bowels not relieved. Face pinched and jaundiced. Vomiting aggravated and still of a bilious color. Further questioning of patient a history of a "lump" in right groin was reported. An examination of this region modified our diagnosis to that of strangulated femoral hernia of the right side. Taxis failed to relieve her and all medication having proved of no avail, operation was at once decided upon and assistance requested.

The next day, Monday, operation was performed by Dr. R. S. Wallace, of East Brady, assisted by Dr. J. L. Campbell and the writer, both of Chicora. The loop of intestine was soon found but proved very difficult to reduce. Bands of adhesions had firmly united bowel, sac and abdominal walls in one mass. After half an hour's labor by a peeling and snipping process the bowel was returned in a fair condition. All of the sac that could be removed was taken away and the sutures introduced. The patient stood the operation well and started on what seemed an uneventful recovery.

Eight days later a serous discharge appeared from drainage sinus, followed by a rise of temperature, and two days later the sloughing of the sac *en masse*. The sinus continued to discharge but was kept of a serous type by antiseptic injections and dressings. All attempts to heal the sinus proved unavailing. The bowels had a tendency to constipation after the operation, but by careful treatment movements were had almost daily. The patient began moving around the house, the bowels becoming harder to move, till February 21, they failed to respond to treatment. This was soon followed by a milky discharge from the sinus, small in amount. The next day the discharge was more abundant, of a brownish-yellow color, being fluid and floating very little solid matter. We now had a fecal fistula resulting from the stricture of the bowels. The amount discharged from the sinus depended somewhat on the condition of the bowels. When a movement *via naturalis* was obtained the discharge nearly ceased. When the bowels became constipated the discharge was enormous, soaking dressings and bedding in a few minutes. Periods of constipation now alternated with loose bowels for four weeks, when the stricture of bowel being regarded of a permanent nature, a second operation was advised.

The second operation was performed by Dr. R. S. Sutton, of Pittsburgh, assisted by Dr. S. D. Bell, of Butler, and those present at the former operation. A coeliotomy in the *linea alba* was selected and an incision 3½ to 4 inches long made between umbilicus and symphisis pubis. The operation was quickly performed requiring but nineteen minutes from first incision till buttons were introduced. The steps in the operation, after locating the loop of intestine involved, were the same as recommended by Prof. Murphy, of Chicago, in his original article. First, introduction of running stitch "purse string"; second, button-hole incision; third, insertion of buttons; fourth, securing "purse string"; fifth, meeting male and female portions of button.

Although this operation has been performed a number of times in abdominal

work since it was given to the profession in December last, this is believed to be the first use of the buttons for artificial anus. Nothing was done with the old sinus, nor the five to six inches of intestine in each arm of the loop below the insertion of the button. The operation was performed at noon on Saturday March, 25. The patient though much emaciated entered the operation without any fear. She rallied well and as in first operation required no morphine or other agent for pain. Was nauseated from the anæsthetic and was restless through the night, sleeping but little. For three days previous, rectal alimentation had been adopted; this was continued with the addition of brandy.

Sunday 26th. Pulse 98 to 112, temperature 98.6°. An urticaria of entire body appeared that entailed much suffering from its intolerable itching, the patient declaring it would drive her insane if something was not done for her relief. Soda and borax bathing failing to relieve, the patient was anointed with the officinal zinc ointment, to which was added three drachms of chloroform per ounce. The relief was immediate and permanent.

Monday 27th. Pulse 95 to 110, highest temperature 100.4°F. Restless. Rectal alimentation continued and one drachm bovinine every two hours added to the diet, the latter *per orem*.

Tuesday 28th. Pulse 95 to 110, highest temperature 99.6°. Insomnia persisting.

Wednesday 29th. Temperature normal. Oedema of ankles. Urinary examination with negative results. From this on there was no elevation of temperature till April 5th, when a small stitch abscess formed in the line where the sutures had been removed four days before; the stitches all being out on the eighth day. On the seventh day broth was added to the diet by the mouth and rectal feeding resorted to less frequently. The bowels moved sooner than we anticipated, the first movement occurring in the first twenty-four hours. It was small and from the lower bowel only, where the alimentation had been maintained for a number of days. On and after the sixth day bowels moved from above and have continued to do so, the tendency to constipation that the patient has had for years being overcome. The sinus discharged less and less and in three weeks bowel contents ceased to pass from fistula and ten days later the sinus healed. From the first the sinus was treated with peroxide of hydrogen, antiseptic injections and iodoform in injection and dressings. The button seemed to leave its moorings on the fifth day as determined by palpation through the emaciated abdominal walls. The nurses were instructed to be very watchful of dejecta for the button. but it failed to make an appearance to their vigilant eyes.

During the convalescence the patient suffered from an attack of acute articular rheumatism. In fact three attacks; one antedating first operation from which she was just recovering; the second between operations, and the third late in her convalescence. Dating from the appearance of œdema of left ankle she was much troubled with phlegmasia in that limb, extending to Poupart's ligament. Repeated examinations of urine, chemically and microscopically, proved negative results. Coupled with this was a frequent micturition which seemed to be entirely of nervous origin. The hernia that became strangulated was an old one dating back to her third pregnancy, some seventeen years before. It had never occasioned her any inconvenience except the mental one—that there was a lump in her groin that ought not to be there. No truss or other support had ever been applied. Our case that started out as strangulated hernia gave us a varied career, the complications being sloughing of sac, stricture of bowels and an artificial anus, besides having rheumatism, phlegmasia, eczema and urticaria as sequelæ to make up the full program.

The only element short of a perfect recovery at this date is a stiffness of knee joints, superinduced by rheumatism plus her long confinement, plus a semi-upright position maintained by patient despite protestations, her weight being supported by her feet resting on a box foot-rest while she reclined on a toboggan slide made of half a dozen pillows. This however is rapidly improving and the patient can be reported as, recovery perfect.

The advantages claimed by Prof. Murphy were exemplified in our case.

No imperfect application of sutures; no sloughing; no imperfect apposition of openings; pressure uniform; no absorbing of sutures too early; length of opera-

tion minimized and shock the least possible for an operation of this magnitude. We had some concern about the loop of bowel that was "switched off," but up to this date has given us no trouble.

NOTE.—Was called to see Mrs. H., August 11th. Complained of intestinal pain. Followed the next two days by vomiting and purging, the pain continuing but in a mild form. Early on Monday morning, four months and twenty days from operation, the button was passed without trouble *per via naturalis*. Will say patient has continued in excellent health, being robust and going about her household duties. G. D. T.

INTUBATION WITH REPORT OF CASES.*

G. D. NUTT, M. D., WILLIAMSPORT.

My object in presenting this paper before you to-day, is not so much to record the results of the small number of intubations that have come under my observation, as to bring the subject of pseudo-membraneous laryngitis before this Society, for a full, free and intelligent discussion.

A disease, so prevalent, dangerous and destructive, certainly should call for more consideration at our hands than has been accorded it in the past. In looking over the transactions for the past five or six years, I fail to find any paper or discussion on this subject except a few remarks in a paper read before this society at Harrisburg by J. M. Batten on "The Treatment of Diphtheria."

The absorbing interest in all surgical diseases as obtained by the introduction of aseptic surgery, and the great advancement and success of abdominal work, has had a tendency to divert professional thought from medical subjects, which generally do not yield such brilliant results.

While mothers are being saved from a torturing death or chronic invalidism by rendering them incapable of producing more off-spring, pseudo-membranous croup is claiming those already born with a frightful mortality.

Jacobi in Pepper's System of Medicine says, "Infants and children under two years almost invariably die." "The percentage of average mortality rates from 80 to 90 per cent." Flint says, "Of twenty-two cases analyzed by Dr. Ware, nineteen proved fatal." Dr. Edward Rosenthal stated in a discussion before the Philadelphia Medical Society, "That in a serious of some four hundred and twenty odd cases which he had followed, and studied in his practice and those of his friends, which were not treated by intubation or tracheotomy, but three recovered." Such figures as these, gentlemen, cannot but arrest our attention and make us shudder at the risk our little ones have to endure, in this fatal disease.

Whether all cases of pseudo-membranous laryngitis are from the same cause, and are but different phases of diphtheria, seems to be a disputed point. While many of our best authorities believe that diphtheria and membraneous croup are one and the same disease, arising from the same micro-organism and only differing in degree, and location, more recent investigations tend to prove that they arise from different bacteria and thus form two distinct and separate diseases.

From a close observation and careful study of the clinical history of diphtheria, and membranous croup, covering a period of twenty-three years and including many hundred cases, I have frequently noted many different phases of the deposit, so much so, that I have long believed we have three distinct varieties or types of membranous formation liable to invade the larynx, differing widely in the character of the deposit, mode, and location of invasion, and results.

In the regular or common form of diphtheria, the disease commences with a high fever, considerable constitutional disturbance, and a membranous deposit of a thick greyish-white, which rapidly forms and spreads over the tonsils, with a tendency to invade the soft palate, nasal passages, or downward to the vocal cords, and larynx. If arrested it soon separates, coming off in thick leathery patches, quite offensive, and very contagious. When severe,

* Read before Penna. State Medical Society, 1893.

the sub-mucous cellular tissue and glands of the neck become infiltrated with the poison, swell, and soon contaminate the system. These cases usually are followed by some form of paralysis. If it invades the larynx it is usually in the latter stage of the disease when the patient has become weak and debilitated; and is in a poor condition for either the employment of tracheotomy or intubation. Consequently the rate of mortality is very high.

There is another form of diphtheria differing from the above in many important features. The invasion presents about the same symptoms, but the membrane is thin and remarkably white in color, rarely has any odor and very little glandular involvement. It spreads over tonsils, pharynx, soft palate and larynx. It is very firmly attached to the mucous membrane, and is slow to separate. It seems to wear off or absorb, rather than become detached. It yields more slowly to the effect of mercurials than the previous form, but does not weaken the patient so much or so rapidly, although the regular paralysis usually follows. Its tendency to invade the larynx, is in marked contrast to the previous form.

In this form it is not unusual for the false membrane to remain on the tonsil or some portion of the mucous membrane two or even three weeks. In one child that had to be intubated, the tube was left in fourteen days before the last vestige of the membrane disappeared.

The third type is the membranous croup of the old writers. It occurs in isolated cases, with but little constitutional disturbance except symptoms of cold and hoarseness. It always invades the larynx and trachea and is never seen above the vocal cords except in small isolated patches. To the naked eye the membrane cannot be distinguished from other forms of diphtheria. It yields readily to mercurials if the system is brought under its influence early. Its contagiousness is very doubtful. It usually attacks only one member of the family and is rarely associated with other forms of diphtheria. Although very fatal, it generally causes death by its mechanical effect. Consequently the results of intubation in these cases are very satisfactory, and yield a good percentage of recoveries if properly managed.

Although the clinical histories of these three forms or types of diphtheria seem so different in their nature and formation as to strongly suggest a different micro-organism, yet practically, the treatment is the same. My observation accords with many others in the value of the mercurial form of treatment, but to insure its effect it must be given early, and in frequently repeated doses, so as to insure its rapid physiological effect. By this treatment the disease is arrested, and the false membrane soon separates or becomes dead.

When the larynx becomes involved its mechanical effect becomes an important factor in the successful management of the case; and whether we should perform tracheotomy, or intubation, and *when*, is a question of vital importance.

My own experience is decidedly in favor of intubation if performed early. Just as soon as the obstructed breathing, and prolonged expiration show that the lungs cannot perform their proper function.

I have performed *tracheotomy* several times for membranous croup but the results have never proven satisfactory. True it was not used until death seemed imminent; but one of the most serious objections to its use, is the inability to obtain the consent of parents and friends before the danger point is reached. It is not only a tedious and bloody operation, but the care that has to be excerised in the after management of the case is a serious obstacle to its success in general practice.

It is not to be supposed that placing a tube in a child's throat alone is going to save our patient. It simly overcomes the mechanical obstruction to breathing, providing the membrane has not extended too far in the trachea; and prevents death from suffocation, thus giving us more time for its future treatment. The subsequent management of the case requires good care, and such modifications of our remedies as the presence of the tube requires.

A warm room heavily loaded with moisture, and the frequent inhalation of steam from slacked lime, are essential to the success of the case. The continuance of the mercurial treatment can best be carried out by allowing the child to inhale the fumes arising from burned calomel.

The proper feeding of the patient is one of the most objectionable features of intubation.

Very little if any liquid should be given by the mouth during the first twelve hours. If the patient is very weak use rectal injections. If necessary, however, to excite cough, in order to expel accumulated mucus, an occasional sip of water may be given. After that period either boiled milk, or lime water and milk, may be given at intervals, while the child is lying on its back with head very low as recommended by O'Dwyer, either in spooonful doses or sucked through a tube or nipple. Any soft, semi-solid substance that has no lumps or hard particles, can be given. Such as corn starch, junket, cup custard and the like.

The patient requires constant watching, especially if the string is allowed to remain in the tube, Eternal vigilance is the price of success.

During a discussion of membranous croup before the Philadelphia County Medical Society about a year ago, I made the remark, that I had had at that time seventeen *consecutive* cases of intubation with only four deaths. I did not mean that was my percentage of recoveries.

When I first began to use the tubes some five or six years ago, the first three cases intubated all died; but the tubes were not introduced until the last moment, when the patients showed decided symptoms of suffocation, by blue lips and tips of fingers, congested lungs, and weak, thready pulse. Although relief was obtained for a time, death soon followed from congestion of the lungs.

The next six cases were intubated in a much earlier stage of the disease and all recovered; followed by eleven more cases with only four deaths. Since that time the percentage of recoveries has not been so good; due in a great measure to the class intubated. During the past year a large percentage of the cases has been of a severe diphtheritic type. I have not hesitated to use the tubes even in apparently hopeless cases if there was a likelihood of giving relief.

In giving a tabulated statement of all the cases intubated up to date, I have for convience and comparison divided them into diphthertic and membranous croup.

The whole number intubated has been forty-four. Recoveries twenty-five, deaths nineteen. Of these, twenty-three cases were diphtheritic croup, with ten recoveries, and thirteen deaths. Twenty-one cases of membranous croup, with fifteen recoveries, and six deaths.

There were eight children under two years of age, with two recoveries, and six deaths. There were fifteen between the ages of two and five years, with six recoveries, and nine deaths. While there were twenty-one five years old and over, with seventeen recoveries, and four deaths. The youngest child was eight months, and the oldest ten years old.

In three cases that died of diphtheritic croup, the croupy symptoms were relieved, and the tube removed, but death occurred later from the systemic poisoning. In a number of cases the membrane was detached at the first insertion of the tube, and in three of these, the tube was never re-inserted; the patients making good recoveries. In one case, as I have mentioned before, the tube remained in fourteen days; the usual length of time being four or five days. In no case was intubation resorted to without there being a deposit in the throat or larynx. If not seen, some portion of the membrane was detached and expectorated when the tube was inserted.

These figures if they prove anything, go to show:—

First. That we have in intubation a most valuable and safe method of lessening the mortality of this fatal disease.

Second. That in all forms of membranous croup, in children under two years old, the mortality is very high but by intubation and careful management we may save some.

Third. That in those between the ages of two and five years, we may reasonably except from 25 to 30 per cent of recoveries.

Fourth. In those that are five years old and over, a large percentage will recover, ranging anywhere from 50 to 75 per cent.

He was Exposed to Success.

Rosevelt—When Bloomstein was in the hospital with us, you remember, we used to consider him stupid. How did he manage to build up such a large and remunerative practice?

Hannemann--He was just shrewd enough to establish himself in a town where the local paper published a column of medical advice each week.—*Puck.*

OSTEO MYELITIS*

O. WELLINGTON ARCHIBALD, M. D., JAMESTOWN, MD.

J. C. H., aged 24, Sykeston, N. D. Some 12 years ago patient fell on frozen ground somewhere in Canada, injuring left leg; says attending physician afterward removed 32 pieces of bone from limb. From that time until he came under the notice of Dr. Cooke during the latter part of December, 1892, had no pain in limb with exception of winter of 1886, at which time, pain described as of dull and aching character lasted several weeks. With that exception limb had seemed perfectly strong and health during the 12 years was good.

When first examined a very noticable enlargement was found over crest and anterior surface of tibia, about the middle, somewhat more reddened than parts adjacent and slightly sensitive to pressure. Patient complained of excruciating, boring pains, greatly intensified at nights and constantly increasing in severity, and diagnosis of periostitis, or osteomyelitis was made and the probable necessity for early operation explained to patient. I directed poultice to be applied at night and tincture of iodine several times during each day. Impossible to secure sleep at night with any kind or reasonable quantity of drugs. About the middle of January, exploratory incision was made the result of which was entirely negative. Some relief followed for several days, after which pains recurred with increasing severity. Osteo-myelitis was determined upon as cause of trouble and patient came to Jamestown for operation. Upon arriving there an operation was made consisting of an incision some 6 inches in length, which resulted in exposing 2 areas of necrosis opposite each other about centre of bone, upon external and internal surfaces, with sinuses running down towards center, from which considerable pus escaped. The establishment of drainage resulted in complete relief, the two openings were packed with gauze tents and patient returned home a week after, with prognosis of probable amputation in near future. After about 3 weeks, during which time I was in correspondence with Dr. Cooke in whose practice the case occured, another and more radical operation was determined upon and performed on Feb. 17th, with the assistance of Drs. Cooke and Moore.

When etherized, the limb was rendered bloodless by use of Esmarch bandage, and tourniquet applied above knee. An incision 8 inches in length was made down centre of anterior surface of tibia, and the flesh together with the periosteum carefully dissected up so as to expose the entire width of bone. Numerous foci of necrosis were found upon surface, and periosteum entirely gone in some places, leaving surfaces of bone rough and pitted. Beginning at upper angle of incision the trephine was applied at four points at intervals of about one inch, the instrument being carried well down to center of bone. The intervening bridges of bone were then removed with mallet and chisel and whole interior of bone for some 6 or 7 inches thoroughly scraped with Volkmann spoon.

A number of pockets containing from a few drops to several drachms of pus were found. Running off from lowest trephine well down to within one and one one-half inches of ankle joint was a cavity 2 inches in length containing fully one-half ounce of pus, the walls of which, after removal of pus and thorough scraping, were found to consist merely of outside, cancellous tissue—to be simply a shell, in fact. Copious bichloride irrigation was used throughout operation and great care exercised to remove every particle of necrotic matter. After careful cleansing and irrigation the wound was tightly packed with Senn's decalcified bone chips and periosteum and flesh sutured with cat-gut, leaving an opening of about one inch in length at center where approximation was impossible, due to result of former operation; wound dressed anti-septically and patient put to bed. Time of operation one hour and 15 minutes. The wound healed throughout by first intention and patient returned home ten days after. Result, perfect recovery.

*Read before North Dakota Medical Society, 1893.

MOVABLE KIDNEY AND SOME NERVOUS AND OTHER SYMPTOMS ARISING FROM IT.*

SAMUEL AYERS, M. D., PITTSBURG.

Mr. President: The subject of Movable Kidney has not, I think, received that consideration which its importancc demands,—and for several reasons.

First. Though Rayer, as early as 1839, brought the matter clinically before the attention of the profession, it is only within recent years that extended studies have been made in this direction; and therefore a knowledge of the subject has not been widely diffused.

Second. The region of the kidney has been generally regarded as terra incognita, almost beyond the hope of exploration, and the organ itself as too inaccessable for direct examination, and

Third. Until the present improved operation for nephrorrhaphy had been devised, nearly all means for the relief of displaced kidney were unavailing.

Hence it is not strange that the body of the profession has been slow to realize the frequency and the importance of the trouble.

Thanks to the efforts of such men as Lindner, Landau, Keen, Litten, Edebohls, Keppler, Scmitt, Newman, Hahn and others, we are in possession of an extensive and valuable literature, and the operation for nephrorrhaphy as now practiced is one of the most important and successful in the field of surgical procedure.

Movable kidney is of much more frequent occurence than was generally supposed by earlier writers, doubtless because it was then not often sought for. Newman quotes 11,000 autopsies in which only 11 cases were found, and Skorszewsky discovered only 32 cases in 1,030 women.[1] But Edebohls, who has recently made a valuable contribution to the subject[2] states that in an examination of 500 women, he found the kidney movable generally on the right side, in 90, or 18 per cent. Lindner discovered the same abnormal condition in one out of every five or six women examined by him.

By movable kidney is here meant the organ freely movable within or out of its fatty capsule for a distance of from two to eight inches or more from its normal position. This is differentiated from the so-called floating kidney, which is generally congenital, and within the peritoneal cavity, having a mesonephron formed by a reduplication of peritoneum. Notwithstanding this distinction, it is probable that both the movable and floating kidney are attended by similar symptoms.

If we begin with the proposition which is indeed quite axiomatic, that a prolapsed organ, no matter where it be, is liable to create mischief and to be a source of pain or discomfort, we shall at once appreciate the harm that may result from a movabie kidney. The traction upon the renal nerve and vessels, the general dragging upon the sympathetic nerves and their ganglia, the reflex irritation thus excited, the undue pressure of the displaced organ, on the bowel or other parts with which it may be in contact are quite enough to create extensive disturbances in the economy. Then again, as has happened, if the kidney becomes incarcerated or twisted so that the circulation or outflow be obstructed, hydronephrosis, may supervene and the life of the patient be imperiled.

Since movable kidney has been so infrequently recognized until recently, and is perhaps now often overlooked, and since as above stated, its presence is usually attended by symptoms both persistent and distressing, it is reasonable to infer that the liver, but especially the pelvic organs have been often unjustly accused; for some organ or structures had to be saddled with the symptoms, and what more natural than to hold the much abused generative organs responsible.

However, there are some extenuating circumstances in cases in which this error has been committed, for the effects of a displaced kidney closely resemble those of pelvic disease, and can often be differentiated only by the results of operation. Edebohls in some of his cases, which

* Read before Penna. State Medical Society, 1893.

1 Diseases of the Kidney, Morris, p. 27.

2 American Journal of the Medical Sciences, Vol. 105, Nos. 3 and 4.

were complicated with various uterine lesions, operated only on these, and found that after the lapse of sufficient time, most of the symptoms persisted, but that after the fixation of the kidney by suture the patient generally recovered, thus proving the dependence of the trouble on the movable kidney.

It must be food for serious reflection to many gynecologists, that after operating successfully on different diseased pelvic organs, including the rectum, they have failed to relieve the patient, who persists in her chronic invalidism, and in the complaint of dragging lumbar pains, and side aches, backache, dyspnœa and dyspepsia, which it had been promised would disappear after the operation. A displaced kidney has been overlooked, and the result is, a failure. The patient is called hysterical, and all sympathy and further assistance denied her. The moral is brief and emphatic—in every investigation of the pelvic or abdominal organs, the position of the kidney should be carefully ascertained.

During the past year I have seen six cases of movable kidney in women, four among my private patients, and two through the courtesy of Dr. Werder, who has kindly permitted this reference to them. In four of these cases, the right kidney only was movable, in two, both organs. In only one of them, a case of Dr. Werder's, has nephrorrhaphy been done, which proved entirely successful. In one of my cases, both kidneys being very movable, the woman had consented sometime ago to operation, but an intercurrent disorder has postponed it.

The symptoms of this abnormal condition are quite marked, and even uniform, as I have observed them and as detailed by other writers. Edebohls, in the paper above referred to, summarizes six leading symptoms in uncompliated cases, which I here quote, "Digestive disturbance, chronic in character, general nervousness, epigastric pain, usually located somewhat to the left of the median line, at or near the free border of the left costal cartilages, cardiac palpitation, inability to feel comfortable or to sleep on left side." In addition to these symptoms, I have noted decideds pinal pain in one case, referred to me as "spinal irritation," great dragging and aching and sense of weight just below the free border of the ribs on the side corresponding to the prolapsed kidney, coccygodynia in one case, severe periodical attacks of pain in the region of the kidney, in one case, which I formerly took to be uncomplicated lumbo-abdominal neuralgia from unknown cause, periods of mental depression, a sense of great fatigue and tire in the lower extremities after the least exertion. Two of my cases had all the stigmata of so-called "nervous prostration," and this has lead me to seriously inquire whether this trouble may not often be the chief cause of some cases of neurasthenia in both men and women.

Dyspeptic troubles were present in all my cases, and of a very obstinate character; also constipation, whether produced by the pressure of the kidney on the duodenum as alleged by some, or whether from the general disturbances of nutrition.

The causes of movable kidney are yet somewhat in doubt. Some writers think it chiefly due to the absorption of perirenal fat, which seems a very plausible theory, though Keen states that in some of his cases the normal amount of adipose tissue still remained. Traumatisms from falls, strains, etc., are also doubtless leading factors in the etiology. Lean persons with lax abdominal walls, and child-bearing are potent predisposing causes. In one of my cases the trouble dated from an attack of typhoid fever, and was much aggravated by a fall some years later.

The diagnosis of this condition is not difficult if the physician will but remember to make a careful examination, and this is usually easy, since movable kidney is commonly found in thin women, with little resistance of the abdominal walls. The method I have pursued is to place the patient upon an operating chair, the plane of which shall be about thirty degrees from the horizontal. The patient lying supine, with legs flexed, the mobile kidney will slightly descend by gravity from its normal position; then by deep upward pressure from behind just below the border of the last rib with the fingers of the left hand, if examining the right kidney, and counter pressure over the front and side of the abdomen, just opposite, there will be little difficulty in outlining the organ, and noting its size and mobility.

Occasionally the kidney will slip up so high under the liver that it cannot be easily dislodged. If the patient now be

instructed to deeply inspire, and hold her breath a moment, the kidney will descend and may be felt to slip back between the fingers of the two hands during expiration or by slightly relaxing the pressure.

The size of the organ and its mobility can usually be quite clearly made out. Some writers advise for the examination that the patient sit on the edge of a chair, leaning forward, with the hands resting on her knees, but I have never had occasion to try this method.

The prognosis of movable kidney is quite unfavorable without operative interference, indeed the organ is perhaps never securely held in position by any plan of treatment save surgical. Temporary benefit by belts, compresses or pads may be obtained, but such measures are extremely disappointing.

If one will firmly compress the loose kidney with the hand, the very best of all supports, while the patient stands erect, and note the facility with which an inspiratory effort will force it from under his grasp, the futility of all ordinary appliances for this purpose becomes at once apparent.

Nephrorrhaphy or the fixation by suture of the kidney to the abdominal wall offers the only permanent relief. This operation as now performed is followed by a mortality of less than three per cent., and by a percentage of recoveries from symptoms varying from sixty to ninety.

In the excellent paper of Dr. Keen,[1] read before the American Surgical Association in 1890, 134 cases are reported as having been operated on by different surgeons, with four deaths. And no more forcible argument could be advanced in favor of nephrorrhaphy in properly selected cases, than that suggested by Keen's 4th case there reported, the patiet being a physician.

But it is strongly advised here that this operation be not hastily or rashly undertaken. A movable kidney is not equally disturbing to all who have it. My friend, Dr. Stewart, of Pittsburgh, recently told me that he found such a kidney in one of his patients who had no symptoms whatever resulting from it, and I have heard of other similar cases. Just as there may be no ill effects from uterine lesions in some women, so there may be no manifestations from a movable kidney. This, though, is doubtless exceptional, and we have good ground for stating that in women and men of nervous temperament, this abnormal mobility of the organ is a leading factor, if not the chief one, in the production of many nervous and painful phenomena.

It is further suggested that where this trouble is complicated with various pelvic lesions, these be first cured and sufficient time allowed to estimate whether the movable kidney is the disturbing agent. In one of my patients who had besides a movable kidney, endometritis, laceration of cervix and perineum, rectocele and hemorrhoids, these last have all been recently repared in order to determine this point.

It is not the purpose of this paper to enter into the details or methods of the operation for nephrorrhaphy. These can be obtained from the most recent surgical works and journal articles, nor does the paper claim to be a contribution to the literature of this important subject. Its aim is to bring the matter again before the attention of the profession; to advise a more careful investigation into the symptoms heretofore attributed too exclusively to disorders of the sexual apparatus; to urge a more thorough examination of the kidney in every case, and the performance of nephrorrhaphy as soon as it is positively determined that the symptoms are serious, that the loose kidney is the offending organ and that other measures of relief have proven fruitless.

1 Transactions of the American Surgical Association, Vol. 8, 1890, p. 181.

Vaseline as a Lubricator.

Novotny Memorabilien warns against the use of vaseline as a lubricator for sounds and other instruments introduced into the bladder, as he has twice found this substance left behind in the bladder, serving as a nidus about which a mass of detritus had collected, and giving opportunity for the deposit of urinary sediments. In one case the quantity thus massed together upon a quantity of vaseline weighed ten grains.

SODIUM BISULPHITE is reported to produce excellent results in tonsillitis and coryza. Tablespoonful doses of a satuated solution are given every hour or two for twenty-four hours, or longer if necessary, the disease being usually controlled in twenty-four hours.

DIARRHŒA IN CHILDREN.*

J. D. WEAVER, Norristown, Pa.

ETIOLOGY.

Logically I feel that I must begin with the *constitntion.* A child born with a vice is so liable to take on a fatal form of diarrhœa in summer that we dread the approach of the heated term. Therefore, if I were going to blot out this trouble, I would begin with the parents, and allow only the sound in body, mind and soul to marry.

2. *Surroundings* have much to do with running out the light of the little one through its alimentary canal. Filthy and heated apartments, coupled with poverty, certainly lower the vital powers to an alarming extent.

3. *Age.* Holt gives in his table the greatest frequency in the second six months. A record of 772 cases shows:

1st six months	119 cases
2nd " "	237 "
3rd " "	149 "
4th " "	125 "
Over two years	142 "

4. *Dentition.* It is possible that in certain cases and at certain times this is a factor in producing diarrhœa; but not often enough for any of us to dismiss an anxious mother with the words, "Oh, it is only teething, and it will not do to stop the diarrhœa at once." Never allow the laity to neglect a diarrhœa.

5. Brings us to one of the great factors, *diet* and *feeding.* Of 1942 fatal cases recorded by Hope and others, 97 per cent. were bottle-fed. I do not remember loosing a single case of diarrhœa that was fed exclusively from the breast. These facts, then, are certainly alarming and it behooves us to make a greater effort to have our girls so trained physically that when they become mothers they shall be able to perform the duties of maternity.

Why is artificial feeding so dangerous in summer? How many cases of diarrhœa have any of us treated this last winter, known as the coldest for many years? None worth mentioning, and these can be accounted for other than by feeding. It cannot be due to the chemical composition of the milk else our babies would fail in winter as well as in summer. Nor is it wholly due to improper or overfeeding, although I am compelled to admit that over-feeding, irregular and too-frequent feeding and the habitual use of improper food, all unite in producing infantile indigestion; and this dyspepsia is a predisposing cause of diarrhœa. But these evils exist in winter as in summer, so my query as to why artificial food is so dangerous in summer is still unanswered. Since diarrhœal diseases occur with greatest frequency in summer, and with exactly the same conditions except high temperature, rarely or not at all in winter, one would naturally suppose that the heat is the important factor. It is true that heat so lowers the vital forces that the usual amount of food, of whatever kind, cannot be digested with the same vigor, but I firmly believe if the food were decreased two-thirds and the hygienic surroundings were in keeping, that the majority of cases of indigestion and diarrhœa could be avoided. We are struck with the fact that the greatest mortality occurs in the first few weeks of continued hot weather, while we would suppose, if high temperature were the sole cause, the last month when the temperature is highest would present the greatest mortality. Holt thinks the reason why July records greater mortality than August is that a certain number of children are born to die. In other words the weaklings succumb; the strong are left and able to withstand the telluric changes. While this is no doubt true, I would add that in August the doctor and laity are more alert and greater care and precautions are taken to preserve a higher standard of health. Dr. Seibert of New York, has studied every summer month for ten years, separately, as to maximum and minimum temperature and relation of these to the prevalence and mortality of diarrhœa. These observations, which I will not here recount, show conclusively that there is no constant relation between the degree of heat and amount of diarrhœa, and consequently heat is not the direct agent that produces diarrhœa.

We now come to the chief causative factor which we believe to be *bacteria,* a certain degree of atmospheric heat and

* Read before the Montgomery County Medical Society, 1893.

artificial feeding being necessary conditions in their formation. Summer heat brings forth a micro-organism that grows and multiplies. In fact its procreative powers are so great that it is not in the mind of man to compute the offspring of a pair for one week, let alone a summer. These live, grow and multiply in artificial food and to this germ we must look for the cause of the great danger of artificial food in summer. The hot season is the one for rapid growth, maturity and decay in the vegetable kingdom, to which most of the specific causes of disease known belong.

PROPHYLAXIS

Having a definite conception of the causes of summer complaint, the prevention is simple, providing the laity will follow instructions.

1. Watch children with a vice; support and build up as best we can.

2. Let the sanitary surroundings be the best that can be provided. House rent is dear, air cheap. If it is a home of poverty persuade the mother to take up her dirty old rag carpet during the summer months and keep the house clean and sweet. I saw an ideal sanitary home the other day—an Italian's. Not a particle of unnecessary furniture, no hangings, no carpets. From cellar to garret as clean as a new pin. Children dressed in a single garment. Everything looked cool and comfortable.

3. Give careful instruction on *foods and feeding*. Ignorance here is fatal. Of course, we will urge every mother to nurse her child at her breast. I have not in all my cases this summer been called to see a child suffering from diarrhœa that was nursed exclusively at the breast. Learn and teach the capacity of a child's stomach; there is not the least danger of feeding too little. Be careful of too frequent feeding. Especially at night I would recommend the latter.

Outside of cow's milk, the physician should exercise great care and judgment if he allow any other kind of food for an infant under two years. "One man's meat is another man's poison," is true also of babies. We are at times compelled to try other than the staple articles of diet, but in all such cases the reason should be clearly given that this particular food is only allowable for this condition. By all milk is considered the chief article of diet, and is the universal food in artificial feeding. Let us get it to the consumer in as perfect a condition as possible. If it is the microbe in the milk that causes indigestion and diarrhœa, let us kill the animal. An enterprising worker found two hours after milking, in 16 drops of milk examined 9,000 bacteria, in an hour more 31,700, and 25 hours after 5,000,000 had developed. As there seems to be no doubt that cholera, typhoid fever, diphtheria, scarlet fever, and diarrhœal diseases are contracted and disseminated from contaminated milk and water, I would suggest that we get our milk from a dairy near at hand so it need not be handled often, nor heated by long exposure in transportation. The dairyman should not feed his cows brewery and deleterious slops, but should keep them in good pasture lands, and in clean and well ventilated stables. See that they get good food and pure water to drink. The milkers should have clean hands, and wash the udders at each milking. They will also see that the vessels are clean and sweet. The milk should be kept at a temperature of fifty degrees till delivered to the consumer. Having the milk properly delivered at the home, it should not be allowed to stand in pitchers, etc., but should at once be boiled. Endeavor before feeding (by taking from and adding to) to bring cow's as near as possible to the chemical composition of mother's milk. Without entering into details of diet for infants, I give a practicable formula from *Annals of Hygiene*: Boil milk, skim off top film (serum albumen), add ten per cent. lime water, twenty-five per cent. boiled water (more or less according to age of child), and thirty grains lactose to each ounce. Should be kept in air-tight bottles or earthen vessels that can be made air-tight, placed on ice and used as needed. By these means you have sterilized milk which cannot sour. You have removed the indigestible serum albumen, increased lime salts, sugar, and water to human milk standard. If we remember that during the first four weeks an infant requires twelve to sixteen ounces of food in twenty-four hours, at two and three months old from twenty to twenty-four ounces, and so on, we are not likely to overfeed. I think very often a child is overfed because the mother is ignorant as to size of organ she is so anx-

ious to fill and glut. At birth the stomach resembles my thumb as much as anything I know of, and holds five drachms; a week old seven drachms, and increases in size in ratio of one for first week, two and a half for the fourth, and so on.

To sum up, prophylaxis demands of us:

1. Care as to surroundings.

2. The education of the laity up to importance of regularity in feeding, dangers of over-feeding and as to proper diet of infants just weaned.

3. Proper restrictions on transportation and sale of milk.

4. The destruction of germs in all foods given, especially milk, by sterilizing, and cleanliness in care of bottles, nipples, etc.

5. Prompt attention to all mild derangements, especially in summer.

6. Lessening amount of food, and increasing amount of pure water during periods of excessive heat.

INTRA-UTERINE ASPHYXIA WITH REPORT OF THREE CASES.*

GEO. F. HULBERT, M. D., St. Louis, Mo.

To those who have had the experience of believing and declaring that the child in utero was living and that everything was all right and looked forward to a happy termination of the parturition then in hand, may possibly from time to time realize the chagrin and sense of defeat when upon the birth the child has been found to be practically dead, yet not dead for the heart still beats with a strong but slow pulsation. Every effort at resuscitation is resorted to; you are cognizant of the fact of air penetrating and distending the alveolar spaces, evidenced by the increased vigor and rapidity of the heart pulsations; and yet in spite of that, after long continued effort, we gradually see slip through our hands the remaining spark of life and the child is in fact dead. It having been my good fortune or misfortune to have three experiences of this character occurring in my obstetrical work, I have deemed it possibly of interest and hope it will be of some value and satisfaction to those who have had or may have experiences of this kind, to peruse these cases and draw their deductions therefrom.

A similarity of circumstances and conditions appertaining to the child as well as to the mother and the character of the labors, and the fact that the normal limits were not apparently encroached upon in any respect, as well as the fact of the peculiar condition briefly detailed above, has emboldened me to call attention to the conditions and to place on record these cases, not that they are especially new or not, but that many others may have had the same or like experience, yet the fact remains that the literature does not abound with information or anything specially calling attention to the class of cases under consideration.

The first case was delivered in a perfectly natural way by natural force; the two subsequent ones were made instrumental deliveries advisedly, simply for the reason that he felt the possibility of a repetition. In all of them he was certain and positive that he heard the fœtal heart not longer than one-half hour before delivery was accomplished; heard it distinctly but somewhat weakened in its force. At the time of delivery in all, the appearance presented by the children as they came through the vulva was one of extreme pallor, with slight if any evidence of cyanosis save a deepened tinge of the lips, with absolute muscular relaxation; there being apparently no response on the part of the muscles to any irritation that might be made. The heart was pulsating at the rate of from 40 to 50 per minute. The usual methods of artificial respiration were resorted to in all, to the extent of introducing the catheter into the trachea and thereby insuring a passage of air into the bronchial tree and alveolar spaces.

*Abstract of paper read before Am. Association of Obstetricians and Gynecologists, at Detroit, June, 1893.

That the air did penetrate was further evidenced by the slight crepitus easily heard during compression of the chest in the expiratory parts of the respiratory act. Artificial respiration was maintained until the heart ceased beating; until it ceased to respond to the stimulus presented by the aeration of the blood by the artificial respiration. In none of them were there any external evidences of pathological conditions, development having been well accomplished. The umbilical cords were not without the normal limits and it was only when the placenta was reached that there were any conditions present that might possibly account for the peculiar condition of the children. Here in all three cases were there found blood clots occupying the placental surface in over half of its area. These clots were well formed, intimately attached to the placental tissue; smooth upon the uterine side. There was nothing indicating the fact that the clot had been torn from the uterine surface, but rather that placental separation had taken place and the clot had formed and become adherent to the placental tissue. So far as the mothers were concerned, they were in average good health; the first a primipara, the last two multipara. The character of labor was not over twelve hours duration and presenting nothing especially attracting attention outside of the fact that the first was one of those cases which might be termed "piston-rod" form of delivery, in that the head was forced down to the peritoneum at each pain, and upon the disappearance of the pain promptly receded to the brim. This was frequently repeated, so much so that he seriously contemplated applying the forceps, and regrets that he did not in order to enable the head to catch beneath the symphysis. The character of the pains were not sustained and vigorous in any of them, but rather more short and inefficient. In none of these cases was chloroform used and in only one, the first, a rectal injection of twenty grains of chloral given during the first stage. The element of compression upon the head was not at all excessive and would not have attracted attention. In the last two cases there was no pulsation appreciable in the cord; in the first case there was no record of this fact. The children were separated from the mothers immediately, and in the first a small amount of blood was permitted to flow through the severed end of the cord. Unfortunately in none of them did he obtain a post-mortem, and as before stated, the only anatomical lesion that he could testify to is the presence of the blood clot occupying an extensive part of the area of the placental surface. There was only a moderate amount of the amniotic fluid following the birth of each child. In the first two cases dilatation was well advanced before the membranes ruptured; in the last case rupture occurred at the beginning of dilatation. The points for consideration are:

(*a*) The presence of the fœtal heart pulsations so soon before delivery.

(*b*) The normal character of the labor.

(*c*) The extreme pallor and relaxation of the child at birth.

(*d*) The presence of the cardiac pulsation after delivery.

(*e*) The absence of any attempt upon the part of the child to perform the respiratory act.

(*f*) The response upon the part of the heart to the benefits of accomplished artificial respiration.

(*g*) The anatomical conditions presented by the placenta.

Pneumotomy in Abscess of the Lung.

J. J. Matignon, of Bordeaux, has made some observations upon a case of pneumotomy for abscess of the lung, which are of practical interest.

He describes the condition of a young man who kept on wet clothes, after falling into the water while perspiring, in July, 1889. The patient felt a distinct chill while in the water, and a week after this exposure he was attacked with a stitch in his right side and had fever. Frequent relapses occurred from imprudence on his part. Aspiration of the chest was resorted to, with injection of eucalyptus-oil. On January 27, 1891, Baudrimont performed pneumotomy for a abscess of the lung. The cavity was washed out with a solution of boric acid, and powdered iodoform was dusted into it. The wound was dressed with gauze and a bandage. Six months later the patient was examined and declared to be well.—*Journal de Medecine de Bordeaux.*

SOCIETY REPORTS.

THE LOUISVILLE MEDICO-CHIRURGICAL SOCIETY.

Stated Meeting July 21, 1893.

MYOMA OF UTERUS; OPERATION; RECOVERY.

DR. A. SCHACHNER (Visiting): Myoma of the uterus removed from a patient thirty-five years of age. She has had this growth, her physician, Dr. Beckels, tells me for about three years. The adhesions were confined to the posterior portion of the tumor. The growth was removed and the pedicle treated extra-peritoneally. The patient made a very nice recovery. I am under obligations to Dr. Cecil for assisting me in this operation. For the first few days the bowels were a little troublesome and obstinate, but this feature was finally overcome by high enemas of fresh ox gall. The stomach was in such a condition that it would not retain any of the salines. Several purgatives were administered hypodermatically which did not seem to have any effect. High injections of ox gall with some sulphate of magnesia finally relieved the bowels, and from that time on she had no further trouble. The uterus weighs two pounds.

MULTIPLE CYST OF OVARY—OPERATION—RECOVERY.

This tumor I diagnosed as one of the uterus, but proved to be a tumor of the ovary, and I judge it to be a multiple cyst. The reason I took it to be a myoma or fibroma of the uterus was that the clinical history pointed to this conclusion. The patient had uterine hemorrhages, and the position and manner in which it fixed the uterus all led me to believe that it was a myoma or fibroma of the uterus, and I gave this as my opinion, and was supported in this by others who had also seen the case. The tumor while in position was very firm, and so firm that the attending physician had questioned the propriety of removal, thinking that there were too many adhesions which would contra-indicate this procedure. I suggested, however, that as the patient was a middle aged woman that an exploratory incision should be made at least to see what the real condition was, and if it proved as extensive as it seemed to be before the incision, the operation might then be abandoned without any practical risks to the patient. A medium incision was made and I passed my hand into the abdominal cavity and down underneath the tumor to try and determine whether there were many intestinal adhesions; this created such a hemorrhage that I concluded we had better push the operation to a close. I enlarged the incision which ran almost to the ensiform cartilage, and fortunately found no adhesions posteriorly; there was a band which anchored it to the abdominal wall 1½ inches in width and ½ to ¾ of an inch in thickness; also quite extensive omental adhesions in which the omental vessels were as large as my little finger. The adhesions were very readily separated and the tumor taken away. From the time the incision was made until I commenced suturing occupied thirty minutes, and from the beginning of the suturing until the operation was completed occupied eighteen minutes, making forty-eight minutes altogether in removal of the tumor. The woman has had absolutely no unfavorable symptom. It is the only laparotomy of this character I have ever seen where the patient never vomited even once; she had some little nausea about the third day. I gave her a whole bottle of citrate of magnesia at one dose; this was very effective and produced such coliky pains that morphine, ⅛ grain, had to be administered. Sutures were removed on the fifth day and the wound had united throughout to the pedicle by first intention. The pedicle of this tumor was also treated extra-peritoneally. It was drawn out, the peritoneum was stitched around it with silk, the pedicle was ligated with silk and hysterectomy pins placed in the stump for support. It is now almost two weeks since the operation and I think I can safely say that recovery is assured. I saw her last night and the case seems to be running a perfectly normal course, and the pedicle, which is entirely without

the peritoneal cavity, is commencing to give way nicely, so I can safely call it a recovery. The tumor weighs fourteen pounds. Several physicians saw the case before the operation and estimated that the tumor would weigh about twenty-five pounds; I estimated it at twenty pounds, and the result shows how deceptive these growths are. We often read of one-hundred pound tumors, but I think in many instances this is an exaggeration. I mean to say that one-hundred pound tumors of the abdominal cavity are an extreme rarity. I believe they are very much oftener reported than they really exist.

I have a case now which is being prepared for operation, in which I do not think the tumor will reach seventy-five pounds, and if it reaches sixty-five pounds I will be a little surprised. I first made a diagnosis in this case of unilocular cyst, but I will say that several gentlemen had seen the patient before me and they all made the same diagnosis. I say this with no discredit to them, as the woman would not submit to a thorough examination. The examination being made through a thin wrapper and only by palpation, and she refused operation until her condition reached such a desperate stage, that she finally consented on the bare chance she still had of recovery. I had her removed to the Infirmary, taking about two and one-half hours to get her there, and made a small incision when a large mass was visible something like the tumor presented in the last case. I inserted a trocar into the tumor but found nothing; I incised the tumor about an inch and a half deep and examined it with my index finger, but still got nothing. Her condition was such that I did not care to push the operation further, and sent her home. She had at the time of the operation a pulse of 130 to 140, and went on the table with this. Six months afterward I saw her with pulse of 80, and told her I would like to make another examination, as I could not make myself believe that there was not a cyst. I told her I would like to introduce the aspirator needle. I introduced the needle and drew off three gallons of fluid; returning in about ten days I drew off two gallons minus 1½ pints; making a total of five gallons minus 1½ pints of fluid, which still left her with a tremendously enlarged abdomen. The measurement of this young woman was fifty-two inches around the largest diameter of the abdomen, the tumor reaching to the ensiform cartilage.

I have carefully weighed all of the fluid withdrawn and will be able to determine accurately in the end how much the tumor weighs.

CASE OF PRECOCIOUS DEVELOPMENT.

DR. J. L. HOWARD: This patient is a little girl eleven years of age who has a good family history; her hygienic surroundings however are not very good. About a year ago she suffered a great deal of pain and tenderness over the mammary region. About the first of June she had distinct hystero-epileptic attacks, very marked, motor convulsions, general opisthotonos, etc. I did not see her until she had had three or four of these attacks. Soon after the first attack she had a hemorrhage from the bowels; without having any fecal evacuation she would have several small stools, probably ½ dram of blood each time, mixed with a good deal of mucous. At first I thought it was a case of membraneous enteritis. Whenever she would have one of these attacks it would be preceded by a hystero epileptic attack, and at the same time she would have this marked tenderness over the mammary region, very painful to the touch. About this time I also noticed a swelling over the mammary region. You will notice she is very poorly developed for her age, and I thought the case would be one of some interest. Dr. Bullock has seen the case with me. It looks like a case of precocious development; she is still having the peculiar attacks; passed some blood to-day. This hemorrhage from the bowels recurs about every two or three weeks without any regularity, lasting probably from twenty-four to thirty-six hours. There is now some swelling of the mammæ, but sometimes it is more marked. She has had scarlet fever, measles, whooping cough and all the diseases peculiar to childhood. I was not able to determine what the attacks were until finally I saw her in one.

The question in my mind has been whether this condition of the mammary glands had anything to do with the hemorrhages from the bowels. They will run their course of twenty-four to thirty-six

hours in spite of anything I have been able to do. No microscopical examination has been made of the stools, but the material has the appearance of stools in membraneous enteritis. The patient is very anaemic as you see.

DISCUSSION.

DR. T. S. BULLOCK: The mammary glands are not nearly so much enlarged or engorged as when I saw the patient about two weeks ago. I have taken considerable interest in the case from the fact of the periodical loss of blood from the bowels, and have been somewhat puzzled to determine the nature of this hemorrhage. The only conclusion that I could arrive at was that it is one of those extremely rare cases of precocious development.

DR. D. T. SMITH: I would like to ask Dr. Howard his reason for pronouncing the convulsions hystero-epileptic. Hystero epilepsy is quite a violent affection, and outside of France is rather rare.

DR. J. L. HOWARD: I simply pronounced them hystero-epileptic for the reason that they were violent, much more so than hysterical attacks. When these attacks come on she will fall down just like we know people do in epilepsy, but she does not froth at the mouth. The attacks simulate epilepsy to such a marked extent that we could not tell the difference until we tried to rouse her. At one time I started to give her chloroform and she immediately came to herself. After that I only had to talk to her of administering chloroform and she would return to her senses.

Dr. T. S. Bullock then read a paper on

URETHRAL GROWTHS, WITH A CASE.

The urethra of the female is more prone than that of the male, to be affected with new growths. They are divided according to their structure. The most frequent are what are denominated carunculæ, and polypi. The carunculæ almost without exception grow from the mucous membrane of the urethra, and are invariably excessively sensitive. The patient complains of intense pain on micturition, sexual intercourse, in walking and upon the slightest contact with the clothing. Pain is increased by the warmth of the bed, and the patient becomes extremely nervous and hysterical. Rarely, however, does serious mental trouble ensue, though one or two cases of suicide are recorded. Polypi in this situation vary in size from that of a pea to a hazel nut. They are usually pedunculated and bleed readily, and are very sensitive. Their most frequent seat is the external orifice on the posterior wall a short distance from the entrance.

Carcinomatous neoplasms are extremely rare and are usually the result of extension from the vulva or vagina. Venous angeiomata affect the urethro-vaginal tubercle, or the anterior half of the urethro-vaginal septum. Not infrequently it attains a large size and projects between the labia. It is not at all sensitive.

Sarcoma—only one case reported.

Prolapse of the urethral mucous membrane, or eversio urethræ is not common. In addition to the prolapse of the mucous membrane, there is a proliferation of the connective tissue. It is met with both in the young before the age of puberty, and also in old multiparæ. In the latter it is thought by Dr. Emmet to be due to pressure during labor, by which the tissues are forced into the urethra from behind causing dilatation of the canal, either partial or extending to the outlet. At the same time there is a laceration of the submucous tissues. The tissues at the neck of the bladder are free and by pressure of the child's head are crowded into the urethra in the same manner as the rectal tissues are rolled out of the anus. This condition may exist for a long time without symptoms, but as a rule after a time it develops extreme sensitiveness and soon creates difficult and painful micturition, pruritus vulvæ and leucorrhœa.

Fibromata also occur. They are painless, have a smooth surface and are elastic. A word as to the diagnosis of urethral neoplasms: Carunculæ can only be confounded with two conditions, one is prolapse of the urethra, and the other syphilitic warty growths. From the first it is distinguished by careful examination, which will reveal the fact that it completely encircles the meatus. From the second by the presence of other evidences of syphilis around the vulva and on other portions of the body.

Urethral venous angeioma is recognized by its color and lack of sensitiveness. Fibromata by their smooth surface, elasticity, painlessness and the fact that they do not readily bleed on manipulation.

Many of these growths may exist without causing trouble. This is the case with small condylomata. fibromata and mucoid polypi. If they attain any size the first symptom is a disturbance in the excretion of the urine. Later, pain in micturition, pruritus, frequent desire to void the urine and dysuria. As the growths enlarge the urethra is dilated, the mucous membrane becomes hyperæsthetic and hyperæmic, and a catarrhal inflammation is set up. Following this are erosions and fissures.

Treatment: If the growth causes no trouble, non-interference is the rule; but if it causes pain or disturbance of function it should be removed. This is best accomplished by excision followed by thorough cauterization with nitric acid, or better still the actual cautery.

The case which I present, is, I think, an interesting one. It is a fibroma. The following is the history elicited:

A. T., aged thirty-two years; came to the University Clinic complaining of "female trouble;" menstruation regular, slightly painful, three to five days in duration, amount of blood lost normal. Has had four children, the last one fourteen years ago; has had two miscarriages, the last two months ago. All of her labors natural; general health good.

Examination reveals a tumor protruding from vulva; it is two inches in length and is attached to the posterior half of the meatus urinarius. It is lobulated, smooth, dry, elastic and painless. The urethra is very sensitive and an attempt at catheterization occasions great pain. She states that she has no pain on micturition, sexual intercourse, or any other symptom traceable to the growth. She says she first noticed tumor two years ago, at which time it was as large as at present. If the statement is true she certainly gives herself little concern about her genito-urinary organs. Except that it is unsightly and may eventually cause trouble by its increase in size; no interference is necessary.

DISCUSSION.

DR. J. G. CECIL: This is such a rare growth, so entirely unlike anything I have ever seen, that I really have no opinion about it. I believe, however, that it ought to be removed with the knife, and I think it will require a microscopical examination to determine the exact nature of it. The question has arisen as to whether this is a tumor of the urethra or not. The base of the tumor occupies or about covers the space between the meatus and the anterior vaginal wall, yet it seems to occupy or involve certainly the lower half of the urethral circle. I should judge that its character was certainly very different from that of common growths which we see in this region, and would be disposed to think that it would probably show up under the microscope as a fibrous growth.

DR. W. L. RODMAN: I think that this growth can be called a tumor of the urethra because it is encroaching upon the lower floor of the canal, but I do not think it had its origin in the urethra; I think it began below. I believe it will prove to be a fibrous growth. The growths that are most liable to occur in the female urethra are the ordinary carunculæ. The growths that occur most frequently in the male urethra are the ordinary papillomatous growths in the penile portion, and the true fibroid polyp, which occurs almost invariably from the prostatic urethra. This I think is a fibrous growth, but fibromas are very uncommon in the female urethra. They are also uncommon in the penile portion of the male urethra being almost invariably limited to the prostatic portion. For this reason and from the appearance of the growth, I think that it began below the urethra, and has simply encroached upon it secondarily. It is an hypertrophied caruncle.

Of course, the treatment is excision as Dr. Bullock says, and the application of some cautery afterward. The best treatment for the ordinary caruncle I believe to be scraping off with scissors and then the application of chloride of zinc, which I prefer to all other things and believe it is the best application that can be made. It is very fortunate that all tumors of either the male or female urethra are nine times out of ten located in the extreme anterior portion, as otherwise it would be very difficult to treat them surgically. The only exception being the fibroid-polyp which I say is almost always limited to the prostatic portion. Necessarily these tumors usually give rise to a great many distressing symptoms, pain, etc. But it is a fact that you may have tumors even deeper situated in the canal with almost no symptoms at all.

I have seen a number of growths of the female urethra, but few in the male.

DR. E. R. PALMER: The removal of the growth in the case shown by Dr. Bullock could certainly be very easily accomplished. I would suggest that it be done by cocanizing the parts, cutting it off and the application of electro-cautery. I do not think the growth involves the urethra at all.

I do not agree with Dr. Rodman in regard to growths of the urethra: In the daily use of the urethrascope it is not infrequently that I find tumors of the male urethra situated back of the cut off muscle.

DR. TURNER ANDERSON: I examined the growth under discussion at Dr. Bullock's office yesterday, and cannot agree with the gentlemen who have spoken that it is not a urethral growth. When we consider that there is no space practically between the meatus urinarius and the anterior margin of the vagina, that the urethra lies in the anterior wall of the vagina, the meatus urinarius is simply surrounded by condensed areola tissue, we must conclude that this is either a growth of the urethra, or a growth of the anterior wall of the vagina. I made a careful examination of it to determine whether it was a growth of the urethra or of the vagina, and so far as I am able to form an opinion it springs from the posterior semi-circumference of the urethra. Dr. Bullock has very accurately described the case, and I am convinced that it is fibrous in character.

As regards removal, there would be no difficulty in doing so, and it is not necessary to discuss that part of the question. There would be very little hemorrhage, as it is wholly disconnected with the vestibule. Operations in this situation are not attended by much hemorrhage unless we open the net work of vessels which are recognized as the bulbs of vestibule. I think if the gentlemen who believe that the growth is not connected with the urethra will make a more careful examination of the case, they would be convinced this growth springs from the posterior portion of the semi-circumference of the urethra, and is fibrous in character.

DR. W. O. ROBERTS: I agree with what Dr. Anderson has said in connection with the origin of the growth, and also as to the treatment. It seems to me that removal with the knife would be very much better than with galvano-cautery. I think there would be practically no hemorrhage, and the result would be better with the knife than with cautery. Experience goes to prove in amputation of the penis for instance, where there is liable to be very much more hemorrhage than in the removal of this growth, results are far better when amputation is done with the knife than when done with galvano-cautery and the danger from sepsis seems to be less with the knife.

DR. T. S. BULLOCK: As stated in my paper, my reasons for believing this to be fibroma was that most other growths in this situation bleed very readily on handling and are very painful. Fibromata are the only growths occuring in this situation that are absolutely painless, smooth, elastic nonfriable, do not bleed, and occasion absolutely no inconvenience unless they attain a considerable size and drag on the urethra, thus creating trouble by their weight.

In regard to treatment, if I can get the patient to consent, we intend to operate upon her at the University Clinic before the class, but I think we will have some difficulty in getting her to consent to the procedure.

As regards the growth being hypertrophied carunculæ—it seems to me if this had been the case she would have noticed it long prior to two years ago.

SUPRAPUBIC CYSTOTOMY, WITH REMOVAL OF THREE STONES, ONE ENCYSTED, FROM THE BLADDER—RECOVERY.

DR. W. O. ROBERTS: The early part of June I was asked to see a case in consultation with Dr. E. R. Palmer for stone in the bladder. The patient was sixty-seven years of age and had been complaining of bladder symptoms for three years. He had been treated by internal medication for one year without any benefit, then he was treated by another physician by washing out the bladder with boric acid solution and using a catheter. He passed water very frequently and soon after he began to use the catheter, he had to use it every few hours. At the time I saw him with Dr. Palmer, he was using the catheter every two hours; he had not suffered any great pain, nor did he have any marked symptoms of

stone. Dr. Palmer had discovered the stone a short time before I saw the case with him. He told me at the time that he was under the impression that the stone was a large one, and most likely encysted. We made a careful examination under cocaine with a sound, and came to the conclusion that there were two calculi. His prostate was examined through the rectum and found to be quite large, but there was no enlargement of the third lobe. Operation was advised, and owing to the large size of the prostate we agreed to do the suprapubic cystotomy. On the 23rd. of June, the operation was performed at the Norton Infirmary, Drs. Palmer, Yandell, Pearce and several others assisting. The bladder was not contracted, we could easily get into it eight or ten ounces of boric acid solution. As soon as the bladder was opened I found two calculi, the smaller of the three here presented, lying loosely in the bladder; after their removal passing my finger high up to the fundus on the left side, I discovered the largest stone presented which you will see is very rough, the rough side of it being adherent to the bladder. After detaching and removing it there was a considerable oozing of blood. The bladder was drained for forty-eight hours by strips of iodoform gauze introduced and left hanging out of the abdominal wound. The patient has gotten along uninterruptedly well, and while he went for two years without passing any water, yesterday he passed naturally a small quantity.

DISCUSSION.

Dr. E. R. Palmer: The case reported is one that has interested me very deeply. I think Dr. Roberts failed to emphasize the fact that the clinical symptoms of stone were entirely absent. The patient is a very charming old gentleman, but like most old men very set in his views and opinions of things; he had been assured that his trouble was cystitis and had been treated by washing and internal medication, and was very much set against instruments. He had never had the sudden cut off in urinating, never had any pain in the glans penis. He had none of the symptoms that would point to cystic calculi. A remarkable feature of the case to me was that for eighteen months he catheterized himself about twelve times per day, about every two hours. He is the father of one of our leading druggists and from whom he had learned the virtue of surgical cleanliness. As he had not passed any water voluntarily for eighteen months, and had been washed without any benefit, I told the druggist that his father must be examined with proper instruments. In passing a steel sound No. 29 French, I was struck with the fact that as soon as I passed it through the cut-off muscle the sound almost dropped into the bladder. The posterior urethra, instead of being constricted by the middle lobe or contracted by general prostatic enlargement, was exceedingly roomy. As the sound dropped into the bladder, it struck a calculus, which delighted me very much because of my belief that we could assure him of decided relief, if not complete cure of his condition. I explained the necessity for operation to both the patient and his son. Dr. Roberts was then in Omaha and I advised waiting until he returned, and then that he be called in consultation. The first stone detected was the large one in the fundus, the second stone I am certain was in the middle zone of the bladder and the third was not found until the operation. The total weight of the calculi removed was about eleven drams, a considerable amount of material being lost with the fragments brought away by washing the bladder after the operation.

In regard to the symptoms, of course one of the best symptoms of stone is *stone*, but this gentleman presented none of the classical symptoms pointing toward stone in the bladder. While they might have been found sooner if his bladder had been examined, yet the doctor who failed to find stone is perhaps excusable for not having done so because of the fact that all the characteristic symptoms of stone were entirely wanting.

Of course the question arises whether there will be complete restoration of the powers of discharging urine. This is dependent upon the recovery of tone on part of the bladder. I believe that his frequent catheterization has preserved his bladder tone although he is nearly seventy years of age. I was more positive and more confident of this than was Dr. Roberts, and I believe he will recover his powers of urination. I was very much delighted last night to hear his son say that his father had passed some water and

that he goes eight hours without emptying his bladder. My instructions were that when he began to feel like emptying his bladder, to place his hand upon the opening not allowing the urine to escape there and attempt if possible to establish a restoration of the normal flow. He, like a great many of our patients, wanted a guarantee of complete restoration, complete cure, etc., but he says to-day that if he does not recover his powers of urination, has to go through the balance of his life with a fistulous opening, he is extremely delighted that the operation has been performed.

Concerning the question of asepsis and antisepsis—if there ever was a case in which the work was done with extreme care, it was the operation in question. No one came in contact with the case except Dr. Roberts and myself, and we both cleansed ourselves most thoroughly and absolutely, instruments freshly sterilized, and every precaution taken, no towel even was allowed to be touched by any assistant, and yet twenty-four hours after the operation the patient had a tympanitic belly, great pain, temperature 90°, and we were naturally very much alarmed. However, it proved to be nothing more than ordinary flatulency of the bowels, which we learned the patient had been subject to before the operation. The man complained of nothing that would suggest the fact that he had had a capital operation performed upon him. The bladder was not seen in the operation, but in attempting removal of the largest stone the incision had to be slightly enlarged. The result in this case I am certain will demonstrate, as has been demonstrated so often, the value of absolute care in work of this kind.

CONTINUED REPORT.

I exhibited at the last meeting of this Society, a young man having a serpiginous chancroid on the penis and sore in the right groin. The patient called at my office to-day and the place in his groin was perhaps ½ of an inch in height, if anything a little longer than it was when I saw it two weeks ago, and certainly very much less promising in the matter of cure than it was when he was before the Society two weeks ago. He has had this trouble for more than a year, and to-day we seared the whole surface with electro-cautery. We seared the chancroid on the penis about a week ago; it is not much better. To day we treated it as I am treating some tuberculous glands of the face with creosote with the hope that we may get the local and specific action of the creosote on any tubercle bacilli that may be at work and keeping up this trouble. The young man in question is otherwise in good health, and the sore on the penis together with the one in the groin have existed for something over a year. They have resisted every possible mode of procedure in the matter of cure that we have employed, and we have tried almost everything.

DISCUSSION.

DR. W. O. ROBERTS: In connection with this case, speaking of the long duration of chancroid: I saw one in a young man that existed for something over a year, and his penis was finally amputated, when complete recovery took place. Amputation was done under the impression that it was an epithelioma. I have another case now that has been in existence for eleven months. A considerable portion of the penis had been destroyed.

Don't.

Don't try to work on the editor's sympathies. If he is a good editor, he keeps his feelings in the background, and has an eye single to business. His duty is not to relieve distress or gratify individuals aspirations, but to entertain (and, if possible, sometimes instruct) his readers as well as he can. A magazine is not an eleemosynary institution.

Don't ask the editor to tear up or burn your article if he can't use it: decent people dislike to destroy other people's property. Don't fasten all your hopes on a single publication, when their are hundreds of them in the land: what is unavailable to one may suit another. Don't try to hold one person, or set of persons, responsible for the success or failure of your literary career.

Don't complain that the periodicals, while heartlessly rejecting your story, or sketch, or verses, have published hundreds that were worse. Perhaps they have; but when you come to conduct a magazine, you will find that one style of writing or thinking can't be made to cover all the ground, and that your individual taste must defer to that of the public.

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SATURDAY, SEPTEMBER 9TH, 1893.

EDITORIAL.

THE PAN-AMERICAN MEDICAL CONGRESS.

The current week has witnessed a gathering of scientific men which is of more than national interest and which is of first importance to medical science in the western hemisphere. Even the meeting of the International Congress, held in this country some years ago has been of less benefit to America than will be the results of this Pan-American Medical Congress. Without any disparagement of medical science abroad, American physicians have been too prone to overlook the superior merits of American medicine and surgery, and to meekly receive as having authority anything labelled imported and warranted genuine. Of recent years there has been a growing disposition on the part of the American profession to assert itself, and the Pan-American Congress has already served notice on our erstwhile teachers that we are no longer merely pupils but that we have acquired the ability and the resources, and are desirous of working side by side with them for the advancement of the science we are mutually devoted to.

To Dr. Chas. A. L. Reed, of Ohio, the General Secretary of the Congress, more than to any other individual is due the credit for originating and carrying to a successful outcome this meeting of scientists from all countries of the new world. By far the greatest burden of the undertaking has fallen upon his shoulders, and to his persistence, tact and indefatigable energy in overcoming obstacles, and arousing and sustaining interest in the project, the success of the Congress must be accredited.

Aside from the fact that this is the first time that medical men from all American nations have gathered in consultation, this Congress is remarkable for being the first medical convention on this continent which has been recognized and encouraged by financial aid by the national government. Congress appropriated $15,000 for the proper entertainment of foreign delegates. Invitations for foreign governments to send delegates were issued in the name of the President of the United States. Federal medical officers were

detailed to act as delegates. Three hundred delegates were named by the governors of the states of the Union. Delegates were apppointed to represent various medical societies and associations, and finally every physician who could do so was urged to attend and take part in the proceedings of the Congress.

But one general session was held. Thereafter the work was divided between twenty-one distinct sections, each devoted to a specialty. Most valuable discussions occurred in every section but, under existing circumstances, the discussions of the section on marine, hygiene and quarantine will probably prove of the greatest interest to the public. This section, presided over by Surgeon-General Wyman of the Marine Hospital Service, who is also at the head of the National Quarantine Service, considered the question of epidemics, immigration and quarantine, and the relations thereto of governmental control and international regulation. The management and equipment of quarantine stations and methods of disinfection received full and careful attention.

Nearly one thousand papers were listed on the program, but many of these were not presented. The most valuable of these articles and discussions will appear in the REPORTER.

PRACTICAL QUARANTINE.

A year ago cholera was epidemic in Europe. This year, there is in Europe probably quite as much cholera, and it is spread over a wider area. Last year in the United States, the fear of an invasion of cholera amounted to almost a panic. This year there seems to be little public dread of the disease becoming epidemic. That the country has recovered from its alarm is largely due to the fact that the newspapers have other material with which to fill their columns by stirring up public apprehension over the business outlook.

The popular feeling of security arises from the fact that attention is not constantly and sensationally directed to the danger. But there is a real reduction of the danger of cholera invasion due to the enforcement of the national quarantine laws, enacted by Congress last February. It was fortunate for the country that the initiation of the new laws was intrusted to the Supervising Surgeon-General of the United States Marine Hospital Service, Dr. Wyman, who has so thoroughly and intelligently established the new order of things that if danger has been at all imminent it has been met and overcome without creating any public apprehension.

Briefly stated the law empowers the Supervising Surgeon-General United States Marine Hospital Service, to oversee all local quarantine authorities; to see that these are efficient and careful, and whenever in his discretion he deems it necessary, to supplement the local work or to take entire charge of it. Otherwise he is to merely advise with the local authorities—not to interfere with them.

Perhaps the most valuable provision of the law is that one which empowers this officer to send abroad to infected ports, assistants, who shall inspect all persons about to come to this country, and give to each a bill of health, without which no passenger can pass the quarantine line into this country. The assistants are officers of the Marine Hospital Service, and have been detailed to serve in the consular offices at Hamburg, Bremen, Rotterdam, Amsterdam, Antwerp, Southampton, Liverpool, Havre, Marseilles, Genoa and Naples,—the principal ports of emigration to this country. As Dr. Wyman has said: "This is a new depart-

ure in quarantine—quarantining in foreign lands—and the ultimate result may be looked for with great interest. Whatever the result may be, certain it is that the presence of these officers in European ports has diminished in a great degree the danger of the introduction of cholera and other diseases from those ports. Their relations, in one or two instances, were in danger of being strained, but this danger has been averted both by their tact and good judgment, and because of the all-powerful United States law, which practically says to foreign officials that should they object to the official acts of these officers, the alternate is the refusal of the bill of health and the cutting off of all commerce between their ports and the United States."

United States consuls in the interior are directed to notify consuls at port of the existence of contagious disease in their localities, or when merchandise or passengers are leaving any section within their respective consulates. Cable reports are sent to head-quarters.

At an infected port or coming from an infected locality, steerage passengers must remain under medical observation for at least five days and their personal effects must be disinfected by steam. Cabin passengers at infected ports, must give proof as to abode during the four days immediately preceding embarkation. If necessary they may be detained and their baggage disinfected. Certain articles of bedding, clothing and merchandise cannot be shipped from an infected port during the prevalance of an epidemic, nor for thirty days after it has been officially declared at an end. At all times rags must be disinfected before shipment to the United States.

When one embarks each emigrant is given a card containing certain information regarding himself and bearing a serial number referring to the manifest which is required by the immigration regulations and which contains fuller information regarding the holder. This card must be stamped at the consulate, again at the quarantine at the port of arrival, again at the immigration depot, and must be retained by the immigrant until he reaches his destination. These cards, together with labels upon the baggage, furnish valuable information to the health officers of the interior states.

The president has the right to restrict or prohibit the entrance of individuals or property coming from such places as he may designate, and to maintain the prohibition so long as by reason of the existence of contagious or infectious diseases in that locality he deems it necessary.

At ports of arrival in this country the precautions are as thorough as it has been possible to make them in the time elapsed since the law went into effect.

The great Canadian border which would seem to offer easy entrance for an epidemic is protected by the Canadian quarantine, which along the St. Lawrence River requires all emigrants, whether or not exposed to infection, to undergo examination at one of the quarantine stations, and to have all baggage disinfected. As a matter of courtesy, U. S. M. H. officers are stationed at Quebec for the purpose of inspecting, disinfecting and labelling baggage, and issuing certificates to immigrants to the United States.

This system, inaugurated and enforced with all the prompt, impartial carefulness, and the high degree of skill that characterizes the medical services of the national government, has thus far proved an efficient protection to the United States from the invasion of cholera. It would be wise to see how it would work when applied to yellow fever.

Don't take your pen in hand till you have something to say which is liable to interest a good many people, and don't be hasty or careless in your way of saying it.

TRANSLATIONS.

SYRINGOMYELIA ARTHROPATHIES.†

In *Le Progrés Med.*, April 29, 1893, Charcot reviews the various arthropathies dependent upon syringomyelia, and which are, as a rule difficult of diagnosis. In the evolution of these complications of locomotor ataxia, the tabetic arthropathies develop rapidly, frequently resulting in dislocations of the affected joints, and often preceeding the other symptoms. Charcot presents the history of a young man, 29 years of age, non-syphilitic, but the son of an alcoholic and grandson of an epileptic who was afflicted with destructive arthropathies of rapid development, having caused in a few days the dislocation of two large articulations. The question arises, are these joint troubles early symptoms of tabes, or in other words, are these tabetic arthropathies? It must be remembered that there is at least one condition in which the arthropathy of ataxia may be closely simulated even in its minuter details, and that is syringomyelia. In the course of this spinal affection may occur not only spontaneous fractures such as are seen frequently in tabetic patients, but also destructive arthropathies of rapid development, at times fondroyant and that appear to differ in no essential respect from tabetic arthropathies. A patient 32 years of age, a butcher by trade, when 25 years of age was affected with an extreme hypersensitiveness of the fingers (especially the points) which persisted for some days and then disappeared. The patient then commenced to complain of his limbs, the articulations of the lower limbs first and then of the upper becoming the seat of acute, rapid, lancinating pains causing him to cry out. These pains were entirely spontaneous. They were not produced nor influenced by movements of the joints, and the patient could use his joints without trouble. Sometimes one joint was affected, sometimes another, in the limbs, but never did the pains appear in the body of the limb nor in the trunk nor head. There was no swelling of the joints, no fever, no modification of the general health. This crisis lasted three months. In May, 1892, seven years after the first attack, the patient suffered from a new onset of acute pains. With this, there was discovered a change in the right wrist which became swollen. A month later the right shoulder was found to be swollen, both swellings occurring without any pain. The swelling gradually disappeared, but a deformity occurred in the affected joints gradually becoming more marked. In the wrist there was a subluxation of the carpus towards the anterior face of the bone of the fore-arm. By drawing firmly upon the hand this could be reduced, and this without producing any painful sensation. The bony extremities were increased in volume and there was some crepitus. The soft parts were in a normal condition. The shoulder was equally deformed. There was excessive mobility and the humeral extremity could readily be dislocated under the coracoid apophysis. On palpation in the neighborhood of the elbow, two foreign bodies could be discovered; one appeared to be situated below the beak of the olecranon in the tendon of the triceps, independent of the articular extremities and perfectly mobile; the other, more voluminous, manifestedly seated in the thickness of the triceps muscle, elongated in form. This patient was afflicted not with tabes, but with syringomyelia.

As regards the pathological anatomy of syringomyelia it is characterized essentially by the formation of a cavity with gliomatious walls on the gray substance of the spinal cord. This lesion, which most particularly develops at the level of the cervical enlargement, invades step by step the anterior and posterior forms of the gray substance (polio-myelitic symptoms), finally destroying the white columns, lateral or posterior (leuko-myelitic symptoms). The most common clinical form of the disease is the progressive muscular atrophy, beginning at the thenar and hypothenar eminences with fibrillar tremors, which are the first to attract attention. This atrophy is generally accompanied by sensation troubles consisting mainly in more or less complete loss of sensibility

† Translated for THE MEDICAL AND SURGICAL REPORTER by W. A. N. Dorland, M. D.

to pain, heat and cold, the tactile sense and the muscular sense being preserved. A third group of symptoms corresponds to a series of cutaneous or sub-cutaneous lesions, bony or articular which are designated under the general name of trophic troubles; they include bullous eruptions, edemas, spontaneous fractures, and arthropathies. The latter are vegetating arthropathies, quite comparable to those which are seen in the hypertrophic form of tabetic articular lesions. These generally develop spontaneously, without any traumatic history; the onset is abrupt, at times fondroyant; without pain, without fever, the articulation and peri-articular soft parts rapidly tumify, the ligaments relax, the joint become loose, and dislocation occurs. On moving the joint crepitation may be elicited. The patients do not suffer. The articulations may be moved, palpated, dislocated without producing any discomfort. Contrary to the tabetic arthropathies which most frequently are situated in the lower limbs, (76 per cent. according to Schrotter), the syringomyelic arthropathies affect generally the articulations of the upper limbs (wrist, elbow, shoulder). At times they appear precisely in advance of the disease, but ordinarily, they are preceded or accompanied by other syringomyelic symptoms, trophic cutaneous troubles, thermo-analgesia, amyatrophy, etc.

From an anatomical point of view these may be distinguished as for the tabetic arthropathies, two varieties, the *atrophic* form, which is rare, and the *hyper-trophic* form which is most common. In the latter the ligaments and the capsule are elongated or destroyed and the bony extremities become movable to excess and loose and rattling. The articular surfaces eroded in places, become deformed either because of partial fractures that result, or because of the bony vegetations that surround them.

ABSTRACTS.

AMERICAN INEBRIATE ASYLUMS.

Dr. Crothers read an elaborate paper on this subject before the neurological section of the American Medical Association, June, 1893. The following is the closing part of the paper.

The most careful authorities of this country and Europe agree in the statement that fully one-third of all cases who come under treatment for periods of three months or more are permanently restored.

Other institutions, where inebriety is treated as a vice or by empirical methods, claim 80 and 90 per cent. of recoveries.

It is needless to add that all such statements are not supported by published statistics.

In view of the chronic character of these cases, and the imperfect means of treatment, the results so far are encouraging, and indicate great possibilities in the future from a better knowledge and control of these cases.

Such is an outline view of the history and present condition of asylums in this country. The rampant empiricism which is so prominent to-day is indirectly rousing up a new interest in all asylums for inebriates.

The increasing crowds of relapsed cases, whose faith in the gold cure specifics have been misplaced, are rapidly filling up all asylums, and come in a measure prepared to accept physical treatment, and to appreciate the needs of means and remedies. There are ideals of the coming means and appliances essential for the successful treatment of inebriety, towards which a few institutions are struggling. Each year's experience brings larger and clearer conceptions, and each institution is becoming more adapted for scientific work in this field.

An outline of the scientific treatment of inebriety in asylums in America will describe some part of the treatment common to each, but not yet attainable in its entirety, because of the numerous obstacles and want of support from public opinion and other conditions.

The situation of an asylum in the suburbs of a city or in the country near

large centres, with ample grounds for retirement and quiet living, is essential. A proper building, equipped with baths and all the appliances for comfort, with means of amusement, joined with ample legal power to hold the patient a year or more, are equally essential.

They should be called hospitals, not only in full recognition of their physical disabilities, but as places where every condition of life can be regulated and every surrounding can be made to aid recovery and restraint. Literally, a quarantine hospital, where isolation and removal of all the exciting causes, combined with appropriate treatment, to build up and restore the deranged functional activities of the organism, can be obtained.

The time of treatment should be from six months to two years, and be governed by the condition of the patient, and extend to a legal control on parole for a long time after leaving the asylum.

In Connecticut the law gives control over all committed cases for three years, whether on parole or otherwise, in the limits of the State.

The hospital should provide exact military restraint, with duties and responsibilities, rewards and punishments, suited to the condition and capacity of the case; also work, amusement, and occupation, both mental with physical, as medicinal agents. Every condition of life should come under exact military control. Baths, exercise, sleep, food, and medicines, all to be regulated and applied uniformly. Each one should be treated as suffering from profound disease of the brain and nervous system, requiring long rest and building up. The general treatment should begin with an examination and enquiry of the facts concerning his past life and present condition. These conditions should be repeated every few weeks, because of the rapid changes and errors which are impossible to guard against in the first and other examinations. The use of spirits should generally be abandoned very early in the treatment, and the return of the drink paroxysm anticipated by the use of drugs, baths, exercises, and special control.

Many of the paroxysmal drinkers are practically epileptics and require similar treatment. They are suffering from grave disturbances of the physical centres, and physical remedies are required in addition to other means.

Other cases are delusional maniacs and paranoiacs, out of harmony with every condition of natural healthy living, and unable to correct and adjust themselves to such conditions. In others, nerve exhaustion is at the bottom of the drink impulse; inherited tendencies, reflex irritations, and many complex conditions which can only be discovered and treated in hospitals. When these are treated the causes are removed and the alcoholic soil is exhausted and dies away.

States of poisoning from stupor to full delirium are made the subject of special treatment, according to the experience and theories of the physician. These acute symptoms, followed by chronic conditions, require equally special remedies and means.

These are some of the general ideals in treatment to which every scientific asylum is moving. All asylums suffer for want of ample legal authority over their cases for sufficient time to secure permanent results. Public opinion regards asylums as of only temporary, and, in most cases, of doubtful value. But the theories of their work are openly termed "fads," and supposed to be founded on some mercenary or selfish purpose. The pulpit, press, and ultra reformers pass by on the other side, like the Levite. Public patronage is withheld, and most all asylums depend entirely on the income of patients for support. Hence, they are more or less crippled in every way. Many asylums suffer from poor location, bad buildings, and surroundings, inability to classify their inmates, and apply special treatment to each one. In many places baths and systematic exercise cannot be secured. The nutritive, hygienic, and physical treatment cannot be carried out on the ideals of the managers; hence, many asylums are using the means within their power, in anticipation and looking forward for larger and more perfect facilities.

The treatment of inebriety not only includes everything found valuable in hospitals for the insane, in reformatories of the most advanced type, and in the modern sanitarian and homes for neurasthenics. The essentials for treatments in each of these classes are required for the inebriate. The asylum managed on the

scientific plan of providing for the requirements of each case must have the power of control, and special buildings given to the hospitals for the insane; the discipline and management of the modern reformatory and the appliances of the best sanitariums and private homes; then it can approximate to a measure of success in the treatment that at present is only an outline. American asylums are leading the world in these directions of practical work, and while no one has combined only in the crudest way these appliances, many asylums are approaching it yearly. Asylums all over the world are at the beginning and infancy of their existence. A great deal of preparatory work must be done before they can reach the first stage of scientific work. The moral remedies by appeals to the will power and morals of the case must pass away. The delusion and palsy of the higher brain centres must be recognized, and dissolutions beginning in the ethical centres extending down to all the lower faculties must be studied. The great fog banks of metaphysical theories of free will, moral depravity, vice, and wickedness must disappear from all conceptions of inebriety, and its practical management in asylums. Asylums and managers who act on the theory that the inebriate is half-wicked and half-sick are crippled. Asylums and managers who attempt by drugs or moral appeals to restore and cure the victim are still far back in the stage of credulity. The specific vaunter, who professes to break up the the symptom for drink, as if it was the disease itself, is an empiric, either ignorant or by design. Asylums and managers who teach dogmatically the nature of inebriety and its only true remedies are not very far along in their scientific work. Asylums who claim large percentages of cures from certain means and remedies are not worthy or confidence.

Inebriety is found, when carefully studied, to be the most complex neurosis of modern research, dependent on heredity and many physical causes, also physical condition and environment, that are not clear to the most minute study. Asylums for treatment so far, by isolating the patient, places him in the best condition for study of conditions and applying means for relief.

The more thorough this study, the wider the range of causes appear, together with the means and methods of relief. The most advanced asylum of to-day follows a general prospective plan of treatment and has no specifics or no special theories that are not open to change and readjustment, besides a few general facts, which stand out like mountain peaks in a new land, all the intervening space is unexplored. No one can speak dogmatically as to where inebriety begins, and what the exact causes may be. No one can explain the varied phenomena of drink storms, of the action of spirits on the physical brain, of the power of hereditary, of the brain condition which demands relief by the craving for neurotics, of the sudden cessation of this drink impulse, under unusual circumstances, of its equally sudden outburst from causes unknown. Even in asylums the same uncertainty exists. Cases that seem restored, relapse, and others that are considered incurable become restored, showing that our present knowledge is very imperfect, and the known is comparatively nothing in contrast with the unknown.

Running through all this phenomena of inebriety is an outline of a uniform movement of cause and effect; of events following each other according to some law; good examples are the periodicities of the drink impulses, and the outbreak of such impulses from the presence of certain conditions that can be foreseen and studied. Patients under care in asylums present a remarkable uniformity of symptoms and progress that is often startling to the student. Not unfrequently such cases can be anticipated and the results of treatment known far in advance. The drink symptom is dependent on some conditions of brain degenerations and changes. It will suddenly die out and disappear under the most adverse conditions and surroundings. Examples are numerous of persons who become temperate, sign pledges, and stop all use of spirits under the most favorable circumstances. Every temperance and revival meeting furnish illustrations of persons who are restored permanently, although the same means have been used many times before with no result.

Persons are known to stop drinking from the slightest supposed reasons, and

in all these cases the last means used are credited with being the active cause.

The true explanation in all these cases is that some change or evolution of brain function has occurred and the drink system has died out.

It is not the last prayer, pledge, or solicitation of others, or the last drug or remedy of special means used that has caused this change. Other and more obscure causes are at work, and the time comes when their action is apparent in the cessation of the drink impulse. Physicians in charge of asylums recognize this fact, and realize that their best efforts are in building up the brain and nervous system, and placing the organism in the best possible condition for both organic and functional change.

Remedies directed to the drink symptom are never curative; a dose of mercury acting on the liver is a more rational method than bromide to check the drink impulse.

Asylum study of these cases show that inebriety is often a symptom or phase of a neurosis which may break out and change to some other form. General paralysis, melancholy, and many forms of insanity, together with tuberculosis, and various neurotic affections follow frequently on the subsidence of the drink craze.

The statement that the gold cure specifics are followed by an increased number of insane among those who have used the treatment must be a literal fact. The proof of such a statement is found in the experience of every asylum, and the general principles of neurotic diseases. The number of such persons cannot be easily determined, but the more powerful the narcotic used to stop the drink symptoms, the more certain insanity and profound degenerations of the brain centres will follow.

All asylums for inebriates suffer from the large number of incurable inmates, persons who, after an uncertain course of treatment, go away, relapse and condemn the asylum for their failure. Much of the current opinion concerning asylums is formed by the irresponsible statements of incurables. Such persons seem to take pleasure in denouncing asylums in every place, and boasting of the intrigues of its inmates. On the other hand, persons who have received substantial benefit conceal all reference to their treatment and residence in an asylum.

The result is that all institutions are judged by the unthinking public from the statements of those who have failed to receive any benefit from its work.

Unthinking physicians who suppose that the control of the drink craze is the central object of treatment often lend their influence to unfavorable criticism of asylum work. This, joined with bitter condemnations of moralists, complicates and increases the difficulties of every practical asylum trying to understand scientifically this new field of medicine.

American asylums have many advantages over all foreign institutions, in freedom from caste and prestige; also in ability to follow independent lines of work and rise above the prejudices and opposition of those who dread change and advance. Some general conclusions may be stated, as follows:

1. The asylum care and treatment of inebriates began first in this country, and has grown and extended to all civilized nations of the world.

2. American asylums have developed the disease theory and the practical character of physical treatment in institutions beyond that of any others in this field.

3. Asylums in this country represent nearly all stages of development and early growth, from infancy and childhood, with its feeble conceptions and infantile efforts, to the boastful assumption and over confidence of youth, on to the dawning truth of early manhood, when reason and judgment begin to reign.

4. A few of these asylums discern some great outline truths which may be stated with confidence as ideals towards which there is a rapid movement.

5. Inebriate hospitals must take the place of jails and station-houses. Such places are dangerous in their mental and physical surroundings by intensifying the degeneration and removing the patient beyond hope of recovery. They are in many cases literal training stations for mustering armies of chronic maniacs that never desert or leave the ranks until crushed out forever.

6. Inebriate hospitals should receive the incurable inebriates and make them self-supporting, and build them up physically and mentally. They would relieve

the tax-payer and relieve society of untold burdens of sorrow and misery.

7. Inebriate hospitals should receive the recent cases and place them in the highest condition of enforced health and vigor, and thus return a large number to health and sobriety again.

8. Inebriate hospitals can be self-supporting when once established. They should be managed on scientific business principles, like military training schools.

9. Inebriate hospitals should be built from money raised by taxes on the sale of spirits, on the principle that every business should be obliged to provide for the accidents which grow out of it.

10. These are the realities which every inebriate hospital is approaching and which all experience points out as practical and literal in the near future.

11. The enebriate hospitals of to-day are only in the infancy of their work, contending with great opposition and prejudice, misunderstood, condemned, and working against innumerable obstacles.

12. Lastly, there is an intense personality in inebriate hospitals to each one of us. They may bring salvation and restoration to some one near and dear. They may be fountains of healing whose influence shall cross and influence our pathway in many ways.

13. Inebriate hospitals and their work are the great new lands which only a few settlers have reached. They are calling to us to come up and occupy, and thus help the race on in the great march from the lower to the higher.—*Quarterly Journal of Inebriety.*

Ectopic Gestation in Both Tubes.

Walter reports a case of tubal gestation in which both tubes were gravid. On opening the peritoneum there was a discharge of fatty blood with clots. The uterus was enlarged; there was a tense cystic swelling, a little larger than a Tangerine orange, felt in the ligament, and a similar one to the right side and behind the uterus. The tumor on the right side proved to be the right Fallopian tube distended with blood. The left mass was found to present in its outer extremity a tear, exposing a firm blood-clot; this was occupied by an apoplectic ovum and tubal mole. The amniotic cavity presented an embryo six centimetres (2⅓ inches) in length; this was so thoroughly saturated with blood that it resembled in color the clot by which it was surrounded. In the right tube the ostium was found completely occluded, its walls intact. In cutting into the mass, it was found occupied by a tubal mole. The amniotic cavity persisted, but no embryo was detected. The wall of the tube and the mole were hardened, and in due course embedded and sectioned for the microscope. Chorionic villi were found in clusters, which demonstrated beyond any doubt that the organized clot in the right tube was a tubal mole. The pregnancy in the left tube was more advanced than in the right. It is impossible to determine whether the pregnancies occurred at the same time,—the one becoming apoplectic and ceasing to grow, or whether it occurred at a latter period.—*British Medical Journal.*

Double Pyosalpinx.

Butler Smyth reports double pyosalpinx, in a woman 26 years of age, in which there was a large, elongated swelling centrally situated, which reached to the umbilicus. This was movable from side to side, but not tender to the touch. The uterus was pushed in front of the tumor, and was distinctly recognized through the abdominal walls. The lower part of the tumor was found in Douglas's pouch. On the left side of the uterus was another fixed swelling, filling the pelvis on that side. The tumors were closely adherent to intestines and omentum, rendering the separation difficult and tedious. They were removed without rupture; which seems to be the preferable plan, rather than to remove the contents by aspiration, as, when the tumor is once emptied, its landmarks are destroyed and the difficulty of the operation increased. In separating a tumor, use the pulp of the finger as much as possible, and thus endeavor to prevent its laceration and rupture. The patient recovered.—*The Lancet*

Don't "give it up" because a particular contribution is declined. As you may learn from the circular which all well-conducted magazines send out in such cases, its non-acceptance may be dictated by considerations irrespective of its intrinsic merit or your ability. A second, or a twentieth, shot may hit the mark which others have missed.

CURRENT LITERATURE REVIEWED.

THE AMERICAN JOURNAL OF OBSTETRICS.

for August.

Dr. Christian Fenger contributes a paper on

Appendicitis,

In which the whole question is thoroughly considered and the recent literature on the subject carefully reviewed. The author reports several cases and the paper which was read before the Gynecological Society of Chicago, is illustrated with several wood-cuts of specimens removed. The advice is given to operate, first, on all cases accompanied by general or diffuse peritonitis; secondly, to operate upon the cases wherever a tumor exists in the region of the appendix, which steadily though slowly increases after the first four or five days of its discovery; lastly, to operate upon the cases that are known as cases of recurrent appendicitis, providing such attacks give signs of gravity.

Dr. Fernand Henrotin discusses

Enterostomy and Drainage in the Treatment of Diffuse Septic Peritonitis.

In a short article read as part of the discussion of Dr. Fenger's paper, he emphasizes the point that in severe general diffuse septic peritonitis with tympanites, from whatever cause, the chances of recovery will be enhanced if two openings are made, one to drain the peritoneal cavity, and the other, an artificial anus, to relieve the distention.

Dr. Edward Sanders presents a paper on "Chronic Oophoritis and its Treatment by Electricity." The paper presents the conditions of life and other causes of the disease and will be continued in the next issue of the journal.

Dr. Robert A. Murray furnishes a

Clinical Report of Cases of Pyosalpinx, treated by Uterine Drainage, with Subsequent Conception.

As a result of the cases observed, he presents the following conclusions:

1. That many cases of pyosalpinx are curable without mutilating operations, if the endometritis be treated by curettage and drainage with strict antiseptic precautions.

2. That true drainage of a pyosalpinx into the uterus is possible and does occur when the tubes and ovaries are on a level with the uterus, and the uterine end of the Fallopian tube is patulous, or can be made so by treating the uterus.

3. That uterine curettage and drainage should be practiced in every case before operation, unless the tubes are very distended and thin, to cure the endometritis, which may and often is a cause of trouble and lack of relief after celiotomy and removal of the organs is performed.

4. That, even after pyosalpinx, frequently the tubes and ovaries are not useless organs, the proof being that pregnancy occurs and the puerperium is normal.

5. That only after proper treatment, the tubes, ovaries, and uterus remaining bound down by adhesions and a menace to life and health, should the radical operation be done.

6. As a matter of observation in large maternities, there are very few cases of puerperal complication due to the presence or results of a former pyosalpinx.

Dr. H. W. Foster reports a "Successful Case of Cæsarean Section."

Dr. Grace Peckham Murray contributes a paper on "Hematoma of the Vulva, with report of a case." The paper is illustrated with an excellent colored lithograph of the existing conditions.

Other papers in this issue are "The Value of Treatment in Pelvic Disease," by Dr. Frieda E. Lippert; "By what Authority are Resections of the Fallopian tubes and Ovaries and the Enucleation of Myomata characterized as 'Surgical Amusement?'" by Dr. A. Martin, of Berlin.

THE CHICAGO MEDICAL RECORDER

for August.

Dr. Edward Wyllys Andrews contributes a paper entitled

Further Experience with a New Treatment of Hemorrhoids

in which he advocates electro-puncture of the pile. In his first experiments he used a hypodermic needle for the double purpose of injecting cocaine and applying electricity to the tumor.

The present form of instrument contains no provision for injecting cocaine, but could be so arranged by making one of the needles hollow. The destructive action of the current very rapidly corrodes any but a platinum needle, and by using fine dental broaches he obtained almost entirely painless puncture. The hollow needle is so much larger as itself to be a little more likely to cause pain. My experience is yet too limited to determine whether it will be better to rely only on external applications of cocaine. So far I have had little or no pain with the broaches. They corrode very fast, and must be renewed. Theoretically a fine copper electrode would be desirable, as shown by the hardening and penetrating action of the copper salts with the uterine electrode.

He has found this method a pleasant and efficient substitute for the hppodermic treatment. On theoretical grounds, he feels warranted in claiming that it will prove safe, and that the cures will be permanent. Should clinical experience develop no cases of embolism, or other dangerous complications, he believes the method can do what the hypodermic method has failed to accomplish in superseding all operative measures requiring anæsthetics and confinement to bed.

The author includes in his paper the report of a number of cases in which he used the method. He stated that it is not adapted to those cases in which there has been long

continued irritation and much resulting hyperplasia. One feature of the electrolysis is the abatement of pain which the author states has followed the electrolytic treatment.

Other articles in this month's issue are an illustrated paper on "Tait's Perineal Flap Operation," by Dr. F. Byron Robinson; "A Consideration of the Traumatic Neuroses," so-called by Dr. Harold N. Moyer; an interesting account of the "Condition of Siberian Lepers and the Means for their Relief," by Kate Marsden; and "The Leprosy Problem," by Dr. William Allen Pusey.

PERISCOPE.

SURGERY.

Treatment of Pulsating Pleurisy and Pneumorthorax.

Ernest Rowell Watkins, of Notingham, has practiced paracentesis of the chest in cases of pulsating pleurisy and pneumothorax with good effect. In the case of a girl 18 years old, who had strained herself by lifting a box, there was a sensation of something having given way and pain in the side and back. After various measures of treatment a distinct pulsation or heaving was noticed in the thoracic parietes, and the hand, when placed on the left side, was forcibly lifted at each pulsation. Ten ounces of pus were removed from below the inferior angle of the left scapula, and a drainage-tube inserted with ultimate complete relief.

Another case, a clerk aged 26, had "wrenched his insidies" and the pains were referred to the left side. Signs of great intra-thoracic pressure followed, and the left side was distended, with the heart pressed over to the right. The chest was punctured and a quantity of air came away with twelve ounces of fluid. From this time the patient improved, and the breath-sounds could be distinctly heard back and front.—*Lancet.*

Estlander's Operation in Empyema.

Sir William Stokes, in treating of the conditions under which empyema is developed, states that the results of the experience derived from the cases operated on in Dublin would tend to show that ultimately Estlander's operation will be deemed applicable to a much larger range of cases than at present. He considered it an important matter to determine the point where the opening into the cavity of the pleura should be. He thinks that situated over the ninth rib, recommended by Godlee, is perilously near the diaphragm. He approved of flushing the pleura both during and subsequent to the operation.

In discussing the views of Stokes, it was stated by Heuston that Estlander's operation was required only in cases of very long standing, where there was a space which could not be occluded unless the chest-wall were allowed to adapt itself to the collapsed lung. He turned the flap of periosteum over the end of the rib, where it had been cut across, and this hindered the absorption of the discharge by the cancellated bony tissue, and thus avoided pyæmia.—*Dublin Journal of Medical Science.*

An Interesting Case of Empyema.

Barlow reports an interesting case of empyema in his service in the children's ward of the University College Hospital. A boy, aged 11 months, had suffered with a bad throat, with swelling of the neck, discharge from the nose, and trouble of his ears. He was admitted into the hospital with a temperature of 104° F., uttering short cries, breathing quickly, and catching his breath, —indications of pneumonia. The upper two-thirds of the right lung were dull, with bronchial breathing and bronchophonic resonance, and the rest of the side gave defective resonance, with weak breath-sound.

A large hypodermatic needle was inserted near the angle of the right scapula, and soon this fluid withdrawn. Under the microscope many pus-cells were seen, and afterwards the presence of micrococci, diplococci, and a few small chains were found. Two days subsequently a free opening was made into the chest, with the removal of a small piece of the ninth rib, and then seven ounces of fluid escaped, and five days latter shaggy lymph came out.—*The Clinical Journal.*

Surgery of the Thorax.

Rickman J. Godlee, of Bromptom, England, in an address before the British Medical Association, presents points of interest on the surgery of the thorax. As to the site of election for incision in empyema, no position is so good, in his opinion, as that opposite the ninth rib, just outside the angle of the scapula. If the chest be very full, a good plan is to place the patient well over on the diseased side, semi-prone, in fact. It will then be found quite easy to reach the ninth rib outside the scapular line by standing behind. The time of removing the tube depends upon the amount and character of the discharge. If the tube should have slipped in through an anterior opening, the original opening should first be enlarged; and, if not found, it may be necessary to make a posterior incision for its removal.

Double empyema is not so rare as might be supposed. The greater number of pulmonary abscesses encountered by him are bronchiectases, and the treatment has not been very successful.—*The British Medical Journal.*

A Case of Traumatic Hernia of the Lung.

E. Massart, of Honfleur, records a case of traumatic hernia of the lung. It occurred in a robust, healthy man, 38 years of age, as the result of a stab wound in the seventh left intercostal space, a little behind the anterior axillary line. The protruding lung former, a swelling in the wound of the size of half a hen's egg; it was smooth, of a rosy color irreducible, crepitating under the finger, and not altered in size by the movements of respiration. The wound had occurred fourteen hours before seen, and the patient complained of severe pain in the part, and his respiration was short, rapid, and embarrased. The base of the tumor was transfixed with a needle carrying a double strand of catgut, with which it was tied in two pieces. The projecting mass was then cut away and the stump was reduced into the pleural cavity. The external wound was closed and rigid antiseptic treatment carried out. The man made an excellent recovery, without either pleurisy or pneumonia.—*The Lancet.*

Antiseptic Intro-pleural Injection.

Sarbony has employed antiseptic intra-pleural injection for the treatment of thickening of the pleura with marked benefit. He uses an injection of 20 grammes (5 drachms) of liquor of Van Swieten in acute pleurisy after performing thoracentesis. In sero-fibrinous pleurisies the same method has been attended with remarkably good results In purulent and encysted pleurisies, and in cases where resolution or absorption cannot be expected, this form of injection is advised.

Another injection has been employed, consisting of iodine 1 gramme (15 grains), iodide of potash 4 grammes (1 drachm), distilled water 35 grammes (9 drachms), which is used daily and continued for eight or ten days. But this is not attended with such satisfactory effects, in the arrest of the pleural trouble, as the injection of Van Swieten's liquor in quantities ranging from 5 to 35 grammes (1¼ to 9 drachms).—*Journal de medecine et de chirurgie pratiques.*

Intra-pulmonary Injections in Pulmonary Tuberculosis.

Gallet condemns the surgical treatment of pulmonary tuberculosis, and objects to antiseptic washes or injection into the parenchyma of the lung, considering them not only useless but dangerous measures.—*La Partique medicale.*

Purulent Pleurisy Opening in the Lumbar Region.

Dubreuilh, of Montpellier Hospital, r a case of purulent pleurisy opening in the lumbar region. A young man presented an emypema, which migrated to the ileocostal space on the left side, and the lumbar abscess was opened by an incision one and one-half centimetres (⅝ inch) in length, discharging a litre (quart) of sero-sanguinolent fluid. It was washed out with boric-acid solution and packed with gauze.—*Gazette medicale de Paris.*

Excision of an Hydatid Cyst of the Lung

Delageniere reports a successful case of this character. A large opening in the chest-wall was made, and a portion of the sixth, seventh, and eight ribs was resected; the cyst was then stripped away.—*La Semaine Medicale.*

GYNECOLOGY.

Premature Sexual Development.

J. Halliday Croom classifies premature sexual development in relation to ovarian tumors, under the following heads: I. Precocious menstruation with early appearance of the external manifestations of puberty. 2. Sexual development without menstruation. 3. Menstruation previous to the development of the sexual organs. 4. Early conception and pregnancy. 5. Premature sexual development associated with tumors of the generative organs.

Of the first class the most striking illustration is the frequently quoted one of de Beau (*American Medical Journal*, vol xi). The individual was born December 31, 1829, with mammæ perfectly formed and mons veneris covered with hair similar to a girl 12 or 14 years old. The catamenia appeared when she was three years old, and continued regularly every month as copious as in a woman. Each period lasted four days. The dimensions of her pelvis were such as would have permitted her to bear children at three years of age. The second class of cases are infrequent. Among the instances that have been mentioned is one by Cook, in "Medico-Chirurgical Transactions" for 1813. The patient was born in 1802; the external pudenda became prominent and covered with a quantity of dark hair when she was 4 years of age. Within four months of her death, in 1809, she began to suffer from convulsions, after which she increased enormously in weight; complexion became florid, cheeks downy, and lips covered with so much hair that she might be said to have a beard. Her voice, formerly shrill, became strong, and the whole contour was that of puberty, except the breasts and general stature; the mons veneris and labia pudenda were as at perfect puberty, covered with long black hair. Menstruation did not occur, and post-mortem examination showed no change in the external organs of generation. Neither ovaries nor uterus were increased in size. Third: menstruation without development of the sexual organs is less unusual than the preceding, but is also rare. Pozzi alludes to

the case of Bernard in the *Lyon medical*, 1887, of a girl who had menstruated regularly from birth up to 12 years of age without any development of the external organs. Fourth: numbers of cases of early pregnancy have been reported by trustworthy authorities. Muller, in the "Cyclopædia of Obstetrics and Gynecology," reported a case of a girl who menstruated at the second year and was pregnant in her eighth. Fifth, in tumors previous to sexual development, upon which this paper is founded, is the case of Forsythe: a child 7 years of age suffered from a large abdominal tumor. Previous to March, the present year, she had been perfectly well, without abnormal symptoms. In this month she was raped by a boy on several occasions, immediately after which she had a profuse discharge from the vagina, which continued almost uninterrupted until admission to the hospital, several months later; shortly after the rape the abdomen began to swell and gradually enlarged, until, on admission to the ward, she had a tumor about the size of a seven months' pregnancy. It was supposed that this was pregnancy, notwithstanding her extreme youth. This was apparently confirmed by the development of the mammæ well-marked linea nigra, copious development of hair over the mons veneris, and a well-marked bruit was heard. The tumor was freely movable, tense, firm, and had apparently no intimate connection with the pelvis. The mobility and absolute solidity decided against the possibility of pregnancy. The patient was carefully examined under an anæsthetic; the remains of the hymen found thick, completely penetrated; vaginal walls smooth; cervix enlarged, soft, and patulous. The uterus was found to be slightly enlarged, over three inches in length. Manipulation caused free hemorrhage. It was supposed to be a sacculated ovarian tumor. An operation was performed on November 25th. The tumor was aspirated, but only a small quantity of sero-sanguineous fluid withdrawn; had no adhesions; was perfectly free in every direction. Abdominal incision had to be enlarged within an inch and a half of the ensiform cartilage, owing to the fact that the tumor was incompressible. It was removed, and found attached to the left side of the pelvis by a long pedicle. The Fallopian tube was greatly distended and tortuous, the opposite ovary small and undeveloped; the uterus was enlarged, corresponding with the dimensions indicated by the sound previous to the operation. The tumor weighed over six pounds.—*Edinburgh Medical Jnurnal*, February, 1893.

Ovariotomy with Pregancy.

Fancourt Barnes, of London, reports the removal of a multilocular ovarian cyst in which there were adhesions of intestine to almost the whole surface of the cyst and the intestines in a state of acute congestion. The tumor was found to spring from the left side of the uterus. which was enlarged about the size of a four months' pregnancy. The abdomen was washed out with clean, warm water and the wound closed with silver sutures. The patient recovered without interruption of the pregnancy.—*British Gynecological Journal.*

Pyosalpinx Opening into the Rectum.

Veit reports two cases of pyosalpinx communicating with the rectum. The first patient had stricture of the rectum close to the site of the perforation. The suppurating tube was removed and the opening in the rectum sutured. Sterilized gauze was introduced into the abdominial wound for drainage. The patient died, seven months later, of phthisis. The second patient had repeated attacks of pelvic peritonitis. Operation was repeatedly deferred; the tubes were distended, and were removed, and the perforation of the bowel found after careful search. The patient died from obscure symptoms, when a circumscribed peritonitis was found in the pelvis,—an encapsulated cavity, which formed a communication with the rectum by a narrow, tortuous, fistulous tract. Veit thinks that this case would have been saved by drainage.—*British Medical Journal*